No.

IN THE

Supreme Court of the United States

COMMUNITY HEALTH SYSTEMS, INC., WAYNE T. SMITH, AND W. LARRY CASH,

Petitioners,

v.

NEW YORK CITY EMPLOYEES' RETIREMENT SYSTEM, ET AL.,

Respondents.

On Petition For A Writ Of Certiorari To The United States Court Of Appeals For The Sixth Circuit

APPENDIX TO THE PETITION FOR A WRIT OF CERTIORARI

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APPENDIX A

RECOMMENDED FOR FULL-TEXT PUBLICATION
Pursuant to Sixth Circuit I.O.P. 32.1(b)

File Name: 17a0282p.06

UNITED STATES COURT OF APPEALS

FOR THE SIXTH CIRCUIT

NORFOLK COUNTY RETIREMENT SYSTEM, et al.,

Plaintiffs,

NEW YORK CITY EMPLOYEES' RETIREMENT SYSTEM; TEACHERS' RETIREMENT SYSTEM OF THE CITY OF NEW YORK; NEW YORK CITY FIRE DEPARTMENT PENSION FUND; NEW YORK CITY POLICE PENSION FUND; TEACHERS' RETIREMENT SYSTEM OF THE CITY OF NEW YORK VARIABLE ANNUITY PROGRAM,

Plaintiffs-Appellants,

v.

COMMUNITY HEALTH SYSTEMS, INC.; WAYNE T. SMITH; W. LARRY CASH,

Defendants-Appellees.

No. 16-6059

Appeal from the United States District Court
for the Middle District of Tennessee at Nashville.
Nos. 3:11-cv-00433; 3:11-cv-00451; 3:11-cv-00601—
Kevin H. Sharp, District Judge.

Argued: May 3, 2017

Decided and Filed: December 13, 2017

Before: COLE, Chief Judge; SUTTON and
KETHLEDGE, Circuit Judges.

COUNSEL

ARGUED: Barbara J. Hart, LOWEY DANNENBERG COHEN & HART, P.C., White Plains, New York, for Appellants. Gary A. Orseck, ROBBINS, RUSSELL, ENGLERT, ORSECK, UNTEREINER & SAUBER LLP, Washington, D.C., for Appellees. **ON BRIEF:** Barbara J. Hart, David C. Harrison, Scott V. Papp, LOWEY DANNENBERG COHEN & HART, P.C., White Plains, New York, W. Michael Hamilton, PROVOST UMPHREY, LLP, Nashville, Tennessee, for Appellants. Gary A. Orseck, Michael L. Waldman, Matthew M. Madden, Daniel N. Lerman, ROBBINS, RUSSELL, ENGLERT, ORSECK, UNTEREINER & SAUBER LLP, Washington, D.C., Steven A. Riley, Milton S. McGee III, RILEY, WARNOCK & JACOBSON, PLC, Nashville, Tennessee, for Appellees.

OPINION

KETHLEDGE, Circuit Judge. The value of shares in Community Health Systems fell immediately after a competitor, Tenet Healthcare Corporation, publicly disclosed expert analyses and other information suggesting that Community's profits depended largely on Medicare fraud. The plaintiffs here, who owned Community shares at the time, allege that the disclosure caused the fall. The district court found that theory implausible because the disclosure came in the form of a complaint, which the market would regard as comprising mere allegations rather than truth. But whatever the merits of that proposal as a general rule, the Tenet complaint at least plausibly presents an exception to it. Moreover, according to the plaintiffs, the market received similar disclosures from another source: namely Community itself, whose senior executives—after trying for several months to lull the market with still more misrepresentations—eventually corroborated much of what Tenet had alleged. And when they did, Community's shares fell once again. The plaintiffs in this case have therefore plausibly alleged that the value of Community's shares fell because of a series of revelations about practices that Community had previously concealed. For that reason and others, we reverse.

I.

A.

This case comes to us at the pleadings stage, so we take the allegations in the amended complaint as

true. *See Kaminski v. Coulter*, 865 F.3d 339, 344 (6th Cir. 2017).

Community runs the largest for-profit hospital system in the country. In 2011 alone, its 131 hospitals made $13.6 billion in revenue. That revenue depended in significant part on Medicare, which reimburses hospitals for treating patients covered by Medicare. Those reimbursements accounted for about 30% of the revenue made by Community's hospitals from 2006 to 2011.

Medicare reimburses hospitals for inpatient and outpatient emergency services, both of which Community's hospitals offer. Inpatient services are reserved for patients who need more than 24 hours of constant care, so Medicare pays hospitals far more for those patients: in some cases nearly ten times more. But Medicare will reimburse hospitals only for services that are "reasonable and necessary." 42 U.S.C. § 1395y(a)(1)(A). Hospitals are therefore obliged not to classify patients as inpatients when less extensive, outpatient services would suffice; otherwise, hospitals can be held liable for fraud. *See* 31 U.S.C. § 3729.

To determine whether a person needs inpatient or outpatient care, most hospitals use one of two systems: the InterQual Criteria or the Milliman Care Guidelines. Both were developed by independent companies with no financial interest in admitting more inpatients than outpatients. The InterQual Criteria were written by a panel of 1,100 doctors and reference 16,000 medical sources; the Milliman Guidelines were written and reviewed by over 100 doctors and reference 15,000 medical sources. About

3,700 hospitals use InterQual and about 1,000 use Milliman—over 75% of hospitals nationwide.

But Community's hospitals were not among them. Instead those hospitals used a system called the Blue Book, written by Community itself. The Blue Book directed doctors to provide inpatient services for many conditions that other hospitals would treat as outpatient cases under InterQual or Milliman. For example, if a patient comes to the emergency room with chest pain—a vague complaint but apparently one of the most common—outpatient care is the standard. Typically, as described in the amended complaint, the clinician runs "two to three sets of blood tests on the patient every six to eight hours to measure the levels of cardiac enzymes (specifically, a cardiac marker known as troponin) in the blood." Elevated levels of troponin mean that the patient has suffered a heart attack or may suffer one soon. "In addition, it is standard practice to perform two electrocardiograms ('ECGs'), which measure changes in heart rhythm that may be indicative of a heart attack[.]" These tests can easily be completed in less than 24 hours, so "it is standard practice for these patients to be treated in observation, rather than admitted to the hospital." Yet the Blue Book required patients to be admitted first—thus potentially increasing Community's revenue tenfold—and then treated as outpatients only after tests showed they were not at risk. Community's Senior Vice President of Quality and Resource Management said as much when she explained that Community wanted "no chest patients" treated as outpatients.

Community had the same goal for many other conditions, including syncope (*i.e.*, dizziness or fainting), pneumonia, gastrointestinal bleeding, cellulitis, and atrial fibrillation. In each case, the Blue Book directed Community doctors to admit more inpatients than other hospitals would. And Community made sure those doctors complied. It required that all doctors receive a copy of the Blue Book and work toward a "goal of ZERO Medicare observations" (*i.e.*, treatment as an outpatient). It paid higher bonuses to doctors who admitted more inpatients. It also required hospitals to use "Pro-MED" software—again written by Community itself—to track inpatient versus outpatient admissions and to set quotas for inpatient admissions. And it required hospitals to fire the doctors (sometimes en masse) who did not meet those quotas.

For all this internal focus on the Blue Book, Community never mentioned the Blue Book in public. Rather, it attributed its profits to the "synergies" and "efficiencies" of its hospital network. During a quarterly earnings call on July 27, 2006, for example, Community's CEO, Wayne T. Smith, said the "strong revenue" was thanks to "the strength of our operating model."

Revenues were indeed strong: from 2006 to 2011, Community bought more than 50 hospitals, nearly doubling its size and tripling its revenue. Its major acquisition was Triad Hospitals, Inc. After that acquisition—and after Community directed Triad to switch from InterQual to the Blue Book—Triad's hospitals saw sharp increases in inpatients and sharp declines in outpatients. One Triad

hospital nearly eliminated its outpatient numbers in a matter of ten weeks.

Over the years Community heard concerns about the Blue Book, both from within its ranks and from without. In 2007, Community's Chief Medical Officer said that the "Blue Book [was] just not adequate." She echoed the words of Triad's managers, who said that insurers would be skeptical about paying for inpatient services if Triad's hospitals switched from InterQual. Community's internal audits found that its hospitals were improperly classifying many patients as inpatients, and Community's own Medicare consultant told management that the Blue Book put the company at risk of a fraud suit.

Yet Community continued to use the Blue Book into 2011, when it set out to acquire another hospital company, Tenet Healthcare Corporation. Initially, Community's directors sent Tenet's directors an offer to buy Tenet's outstanding shares. When Tenet declined, Community initiated a hostile takeover. Community announced that it would nominate its own slate of directors for Tenet's board, and sought to win the votes of Tenet's shareholders by touting its own "reputation for superior operating performance"—without mentioning the Blue Book as a reason for that performance. Community filed this statement, and others like it, with the SEC.

On April 11, 2011, Tenet sued Community, alleging that those statements were false and misleading. According to Tenet, the statements omitted the real source of Community's profit: namely the Blue Book, which Tenet said directed Community's hospitals essentially to defraud

Medicare. The complaint ran for 208 paragraphs, detailing at length how the Blue Book directed doctors to classify patients suffering from various conditions, and how those directions differed from the industry standard. The complaint also described the reports of two healthcare consulting firms that Tenet had hired to compare Community's patient data to that of other hospitals. The firms found that Community treated about 60% fewer patients as outpatients than the national average, and that this discrepancy was not due to the locations or types of patients seen at Community's hospitals. Instead, according to Tenet, the data led "to a single, inescapable conclusion: patients whose medical needs likely required treatment in outpatient observation . . . were systematically admitted for higher-paying inpatient treatment at [Community's] hospitals." This practice, Tenet alleged, "has served to overstate [Community's] growth statistics, revenues, and profits, and has created a substantial undisclosed financial and legal liability[.]" (Community later paid the federal government $98 million to settle multiple suits for Medicare fraud.) Moreover, Tenet alleged, "[b]y failing to disclose its improper business practices and substantial liabilities," Community had "made false and misleading statements and material omissions to its own shareholders."

Later that day, Community issued a press release denying Tenet's allegations as "completely without merit[.]" In a discussion with a Wells Fargo analyst, however, Community's CFO, Larry Cash, conceded the truth of one allegation: that Community's hospitals did in fact use the Blue Book. But Cash claimed that about 30 of Community's

hospitals had already stopped using it, and that the rest would do so by the end of the year—without losing revenue. After those assurances, Wells Fargo maintained its high rating of Community's stock. Yet Community's stock price fell 35% that same day.

In the following weeks, Community made further admissions: that it had received a subpoena "in connection with an investigation of possible improper claims submitted to Medicare"; that it was the defendant in a suit brought by an internal whistleblower, whose allegations were similar to Tenet's; and that in 2010 an investment group had complained privately to Community about its "aggressive and unsustainable" Medicare billing practices. Meanwhile, Community's officers continued to deny Tenet's allegations and sought to mitigate their impact. Smith, the CEO, said in a press release that Tenet's claims were "irresponsible and inaccurate" and that Community's "business practices are appropriate." Cash, the CFO, said at a conference that the Blue Book was "fairly close" to InterQual in guiding inpatient admissions. Community also released a 112-page presentation to support Cash's claim that switching from the Blue Book to a more standard system would not hurt revenues; according to the presentation, the increase in inpatients at Triad's former hospitals had not been due to the Blue Book, but rather to "improved case management" and a "strong flu season."

In response to these tactics, Community's stock price steadied for a time. But the stock began to decline again during the summer of 2011. Eventually Community withdrew its offer to acquire Tenet. Then, on October 26, Community issued a press

release that disclosed its earnings from the third quarter of its fiscal year. The release showed that Community's revenues were lower—and that its hospitals had admitted 7% fewer inpatients—than during the same quarter the year before. J.P. Morgan was "surprised" by the decline. Wells Fargo added that, in light of the weaker admission numbers, Tenet's claims "might have more validity than originally thought[.]" On a conference call that same day, Cash admitted to analysts and investors that the losses were related to phasing out the Blue Book; seventy-five percent of the hospitals that had done so had seen a decline in inpatient admissions. Smith admitted on the same call that "there's no question we've had some adverse impact related to issues . . . around the Tenet lawsuit."

The next day, Community's share price fell another 11%. All told, from April 11, 2011 (the day Tenet filed its complaint) to October 27, 2011 (the date after Community's earnings report and its executives' admissions), Community's shares lost more than half their value—falling from around $40 to just under $18. The plaintiffs lost a total of $891 million. Yet Smith and Cash avoided similar losses, having sold many of their Community shares before they began to bring the Blue Book in line with industry standards. Those sales brought them each over $7 million.

B.

The plaintiffs here are Community shareholders. Three different shareholders initially filed putative class actions in May and June 2011, each alleging that Community, Smith, and Cash had inflated Community's share price through false and

misleading statements. The district court consolidated the three cases in January 2012, appointed a group of New York pension funds as lead plaintiffs, and allowed the Funds to file a new, consolidated complaint. In that complaint, the Funds defined the class as persons or entities that held Community shares between July 27, 2006 (when Smith credited Community's revenue to its "operating model" rather than to the Blue Book), and April 8, 2011 (just before the Tenet complaint and the first major drop in Community's share price). The Funds alleged that the defendants' alleged fraud had caused these shareholders' losses because the losses came as soon as the market learned of the fraud.

The defendants moved to dismiss the Funds' complaint. Two years later—after a series of recusals by a series of district judges hearing the case, and without a ruling on the motion—the district court allowed the Funds to amend the complaint. This time the Funds expanded the class to include anyone who had held Community shares until October 26, 2011. The defendants moved to dismiss this amended complaint as well.

The district court found that the new allegations in the amended complaint—specifically that Community, Smith, and Cash had made misleading statements from April 11 to October 26, when Smith and Cash then made damaging admissions—were untimely. As to the other allegations, the court found that the Funds had sufficiently pled that the defendants made misleading statements, and that they did so intentionally. But the court held that the Funds had not adequately alleged that the

misleading statements had caused the Funds' losses. The court therefore dismissed the case.

This appeal followed.

II.

We review both grounds of the district court's decision de novo. *See Durand v. Hanover Ins. Grp., Inc.*, 806 F.3d 367, 374 (6th Cir. 2015) (timeliness); *Sanderson v. HCA-The Healthcare Co.*, 447 F.3d 873, 876 (6th Cir. 2006) (failure to state a claim).

A.

The Funds argue first that the allegations in the amended complaint are timely because any new allegations relate back to those in the original consolidated complaint. The Funds' claims of securities fraud are subject to a two-year statute of limitations, which begins to run (as relevant here) when the plaintiff discovers the alleged fraud. *See Merck & Co., Inc. v. Reynolds*, 559 U.S. 633, 653 (2010). No one disputes that the original consolidated complaint was timely: the Funds first discovered the defendants' alleged fraud no earlier than April 2011 (when the Tenet suit was filed), and the Funds filed the consolidated complaint less than two years later, in July 2012. Nor does anyone dispute that, absent some other rule, any new allegations in the amended complaint are untimely: the Funds filed that complaint on October 15, 2015, well over two years after the events at issue here.

But there is some other rule here. Under Federal Rule of Civil Procedure 15(c), otherwise untimely allegations in an amended complaint become timely if they "relate back" to allegations in the initial complaint. Specifically, allegations relate

back to the original filing if they "arose out of the conduct, transaction, or occurrence set out—or attempted to be set out—in the original pleading[.]" Fed. R. Civ. P. 15(c)(1)(B). As interpreted by our court, this standard is met if the original and amended complaints allege the same "general conduct" and "general wrong." *Durand*, 806 F.3d at 375. For if the original complaint puts a defendant on notice of the plaintiff's general claim, then new allegations that merely build on that claim should come as no surprise. *See United States ex rel. Bledsoe v. Cmty. Health Sys., Inc.*, 501 F.3d 493, 516-18 (6th Cir. 2007).

That is all that the allegations in the amended complaint did here. The original complaint alleged that the defendants defrauded investors by concealing the Blue Book's role in padding Community's bottom line, and that the Tenet suit aimed to expose that fraud. The amended complaint built on that claim by alleging more expressly that, after the Tenet suit was filed, the defendants engaged in a series of lulling misrepresentations that were designed to preserve the fraud's effect. Those later misrepresentations included, among other things, the falsehood that the Blue Book was "fairly close" to the industry standard in its effect on inpatient admissions. Eventually the artifice fell away when Community's earnings report for the third quarter of 2011 belied its lulling misrepresentations and Community's own executives admitted that the reason for those disappointing results was—notwithstanding its recent assurances—its discontinuation of the Blue Book procedures. The lulling misrepresentations thus served the same function as the earlier ones: to

convince investors that Community's revenues were sustainable when in fact they were not. All the misrepresentations served the same fraud.

Both the original and amended complaints therefore allege the same "general conduct": namely that the defendants obscured their improper admissions practices both before and after the Tenet complaint. *Durand*, 806 F.3d at 375. And both allege the same "general wrong": namely that investors bought and kept Community's artificially inflated shares only to lose their investments when the artifice was revealed. *Id.* The allegations in the amended complaint thus relate back to those in the original complaint. Indeed, most of those allegations were already in the original complaint, which recites the defendants' allegedly misleading responses to Tenet's complaint. (The district court seemed to overlook those allegations in finding the amended complaint untimely.) Of course, the amended complaint did expand the class definition to include investors that held their stock until October 2011, rather than until only April 2011. But that change only conformed the class definition to the scope of the same fraud "set out" in the original complaint. Fed. R. Civ. P. 15(c)(1)(B). That should have come as no surprise. The allegations in the amended complaint were therefore timely.

B.

The Funds next argue that the district court erred in dismissing the amended complaint for failure to state a plausible claim of securities fraud under § 10(b) of the Securities Exchange Act and the SEC's Rule 10b-5. To state a claim under those provisions, the plaintiffs must allege that the

defendants made material misrepresentations or omissions in connection with the sale of a security, that they did so with bad intent (*i.e.*, scienter), that the plaintiffs relied on the misrepresentations or omissions, and that they eventually suffered an economic loss as a result. *Ohio Pub. Emps. Ret. Sys. v. Fed. Home Loan Mortg. Corp.*, 830 F.3d 376, 383-84 (6th Cir. 2016).

As to those elements, there is considerable common ground in this appeal. Nobody disputes that the amended complaint plausibly alleges that the defendants made false and misleading statements about the source of their profits, and that they did so with an intent to mislead the market. The latter point is where many securities claims fail, since even in their initial pleadings plaintiffs must set forth allegations that, if proved, establish a "strong inference" of fraudulent intent. *Matrixx Initiatives, Inc. v. Siracusano*, 563 U.S. 27, 48 (2011). Yet here the plaintiffs met that standard, not least because of the remarkable timing of Smith's and Cash's stock sales.

Instead the only element at issue here is causation, *i.e.*, whether the plaintiffs plausibly alleged that "the act or omission of the defendant alleged to violate [the Securities Exchange Act] caused the loss for which the plaintiff seeks to recover damages." 15 U.S.C. § 78u-4(b)(4). As pleading requirements go, this one is "not meant to impose a great burden upon a plaintiff." *Dura Pharm., Inc. v. Broudo*, 544 U.S. 336, 347 (2005). Rather it is meant to prevent disappointed shareholders from filing suit merely because their shares have lost value and then using discovery to

determine whether the loss was due to fraud. *Id.* at 347-48. Thus, at the pleading stage, a plaintiff need only "provide a defendant with some indication of the loss and the causal connection that the plaintiff has in mind." *Id.* at 347.

Plainly the loss that the Funds had in mind is the value that their Community shares lost when the market realized that Community's revenues were padded with improper inpatient admissions. And the "causal connection" they had in mind is that "the market reacted negatively" when those fraudulent practices were revealed. *Ohio Pub. Emps. Ret. Sys.*, 830 F.3d at 384. Whether the plaintiffs adequately alleged that causal connection is the nub of the issue here. Sometimes defendants reveal their own fraud via a "corrective disclosure," *i.e.*, a statement that reveals what the defendants themselves previously concealed. But such admissions can be hard to come by, and courts have otherwise held that revelations can come from many sources, including whistleblowers, analysts, and newspaper reports. *See FindWhat Inv'r Grp. v. FindWhat.com*, 658 F.3d 1282, 1311 n.28 (11th Cir. 2011); *see also, e.g.*, *Pub. Emps. Ret. Sys. of Miss. v. Amedisys, Inc.*, 769 F.3d 313, 323 (5th Cir. 2014) (Wall Street Journal article). Likewise such revelations need not come all at once, but can come in a series of partial disclosures. *See Katyle v. Penn Nat'l Gaming, Inc.*, 637 F.3d 462, 472 (4th Cir. 2011). Of course, for the revelation to cause the plaintiffs' losses, the information must in a practical sense be new; otherwise the market will have processed and reacted to that information already. *See Rand-Heart of N.Y., Inc. v. Dolan*, 812 F.3d 1172, 1180 (8th Cir. 2016). And the plaintiffs must allege more than that they bought the shares

at an inflated price, since they could resell at that price and thus not lose anything. *See Dura*, 544 U.S. at 342.

Here, the plaintiffs point primarily to two disclosures in particular: first, the Tenet complaint in April 2011 and Cash's related admission that Community used the Blue Book to guide inpatient admissions; and second, the defendants' October 2011 admissions that earnings were down and that Community's phase-out of the Blue Book played a role in that fall. As proof that these disclosures caused their losses, the Funds point out that Community's share price dropped immediately after the disclosures hit the market—by 35% the day of Tenet's complaint, and by 11% the day after the defendants' October admissions. Moreover, the Funds allege that these disclosures brought new information to the market. According to them, the Tenet complaint revealed exactly what the defendants had for years concealed: that the Blue Book was propping up revenues. And in October the defendants themselves revealed what they had for months denied: that Tenet was right.

Taken together, these disclosures—and the speed at which Community's share price fell after them—make it at least plausible that the disclosures had something to do with the Funds' losses. *See Robbins v. Koger Props., Inc.*, 116 F.3d 1441, 1447 (11th Cir. 1997). There might have been other causes. But whether the Funds' losses flowed from the disclosures, Community's failed merger with Tenet, or anything else is for the parties to dispute at the summary-judgment stage or at trial, rather than for us to decide on the pleadings here. At this point it

suffices to say that the complaint gives the defendants ample indication of the causation theory that the Funds intend to advance. *Dura*, 544 U.S. at 347.

Yet the defendants argue, and the district court held, that Tenet's complaint could not reveal the truth behind their prior alleged misrepresentations because complaints can reveal only allegations rather than truth. Although that proposition might have merit as a general rule, we reject it as a categorical one. As an initial matter, every representation of fact is in a sense an allegation, whether made in a complaint, newspaper report, press release, or under oath in a courtroom. The difference between those representations is that some are more credible than others and thus more likely to be acted upon as truth. Statements made under oath are deemed relatively credible because the speaker typically makes them under penalty of perjury. *See, e.g.*, 18 U.S.C. § 1621. And a defendant's own admissions of wrongdoing are credible because they are statements against interest. *Cf.* Fed. R. Evid. 804(b)(3). Mere allegations in a complaint tend to be less credible for the opposite reason, namely that they are made in seeking money damages or other relief. But these are differences of degree, not kind, and even within each type of representation some are more credible than others. Hence we must evaluate each putative disclosure individually (and in the context of any other disclosures) to determine whether the market could have perceived it as true. *See, e.g.*, *Amedisys*, 769 F.3d at 322-26.

Here, two aspects of the Tenet complaint set it apart from most complaints for purposes of that determination. The first is separate from the complaint itself: Community's CFO, Cash, promptly admitted the truth of one of the complaint's core allegations, namely that Community had used the Blue Book to guide inpatient admissions. Cash's admission was only partial: although it revealed a material fact that Community had been careful to omit in its representations to investors, it did not itself reveal the full extent to which the Blue Book inflated Community's revenues and subjected Community to potential liability. But it is easily plausible that Cash's admission, together with the relevant allegations in the Tenet complaint, revealed a material fact that Community had previously concealed from the market. This case is thus similar to one where the announcement of an SEC investigation, in addition to an admission by the defendant, amounted to a corrective disclosure. *See Lloyd v. CVB Fin. Corp.*, 811 F.3d 1200, 1209-11 (9th Cir. 2016); *see also Meyer v. Greene*, 710 F.3d 1189, 1201 n.13 (11th Cir. 2013).

Second, the Tenet complaint itself included expert analyses that did describe the extent to which the Blue Book inflated revenues and exposed the company to liability. Specifically, as noted above, two different consulting firms with expertise in the healthcare industry compared Community's inpatient admissions to those of other hospitals, and separately concluded (as Tenet put it) that Community systematically admitted as inpatients "patients whose medical needs likely required treatment" only as outpatients. The latter conclusion in particular—that Community not only admitted

more inpatients than other hospitals, but did so in a manner that was clinically improper—was beyond the ken of most investors, and thus revealed new information to them. *See Amedisys*, 769 F.3d at 323; *compare Sapssov v. Health Mgmt. Assocs., Inc.*, 608 F. App'x 855, 863 (11th Cir. 2015) (investment analyst's report that merely summarized a whistleblower complaint filed months before was not new information). Indeed, that the propriety of Community's inpatient admissions was beyond the ken of most investors is arguably the reason why Community's later attempts (allegedly) to lull them were to some extent successful. And Community offers no reason now (other than the analyses' placement in a complaint) to think that the market regarded the analyses' new information as anything other than credible. It is at least plausible, therefore, that the expert analyses in the Tenet complaint revealed a truth that Community had until then fraudulently concealed: that the Blue Book had improperly inflated Community's inpatient admissions and thus its profits.

Community argues further, however, that neither disclosure—that Community used the Blue Book to guide inpatient admissions, or the expert analyses of the Blue Book's effect—was truly new. Specifically, Community says the Blue Book was copyrighted and thus presumably available for inspection at the Library of Congress. We pass over for now the question whether a document's mere availability at the Library of Congress means, as a matter of law, that the market is presumed to know about its contents. For on the record as it comes to us here, Community's own alleged fraud left investors with no idea that the Blue Book (not to mention the

paraphernalia used to implement it, like Pro-MED) was a device to inflate Community's revenues. Market participants thus had no greater reason to travel to Washington to inspect the Blue Book than they had to inspect, say, Community's articles of incorporation. The reality (at least plausibly), therefore, is that the disclosure that Community used the Blue Book to guide inpatient admissions was news to the market.

Community similarly contends that the expert analyses did not convey new information because the two consulting firms used publicly available admissions data in comparing Community's inpatient admissions to those of other hospitals. In fact only one of the consulting firms used such data; the other used data that was not publicly available. But more to the point, Community overlooks the gravamen of the experts' analyses, which (as discussed above) was not merely that Community inflated its inpatient admissions, but that it did so in ways that were clinically improper. And that quite plausibly came as news to investors.

Finally, Community argues that the Tenet complaint revealed no new information because investors could have read that information in a whistleblower complaint that a Community employee had filed under the False Claims Act. But that complaint alleged fraudulent billing only at the specific Community hospital where that employee worked. It thus remains plausible that the market first learned the full extent of Community's alleged fraud from Tenet's complaint.

The Funds have therefore plausibly alleged corrective disclosures that revealed the defendants'

antecedent fraud to the market and that thereby caused the plaintiffs' economic loss. Thus the Funds have stated a claim for securities fraud.

* * *

The district court's judgment is reversed, and the case remanded for further proceedings consistent with this opinion.

APPENDIX B

UNITED STATES DISTRICT COURT
MIDDLE DISTRICT OF TENNESSEE
NASHVILLE DIVISION

NORFOLK COUNTY RETIREMENT SYSTEM, individually and on behalf of all others similarly situated,	)	
Plaintiff,	)	**No. 3:11-00433**
	)	**Judge Sharp**
v.	)	
COMMUNITY HEALTH SYSTEMS, INC., WAYNE T. SMITH and W. LARRY CASH,	)	**June 16, 2016**
Defendants.	)	

MEMORANDUM

In this consolidated class action alleging securities fraud brought by Plaintiff Norfolk County Retirement System ("Norfolk County"), Defendants Community Health Systems, Inc. ("CHS"), Wayne T. Smith, and Larry Cash have filed a Motion to Dismiss the Amended Complaint (Docket No. 177). Plaintiff has filed a response in opposition (Docket

No. 185), to which Defendants have replied (Docket No. 191).

After the motion was fully briefed, the case was transferred to the undersigned, and the Court heard oral argument on April 11, 2016. For the reasons that follow, Defendants' Motion will be granted.

I. Factual Background

The complaint is now in its third iteration, spans more than 130 pages, and contains 507 paragraphs. For present purposes, the relevant factual allegations can be summarized as follows:

A. Overview

Plaintiff Norfolk County has more than 8,200 active and retired members from 40 governmental units throughout the County of Norfolk, Massachusetts, and has approximately $600 million in assets under management. It claims to have been damaged by the purchase of publicly-traded common stock of CHS at artificially-inflated prices during the class period, which runs from July 27, 2006 through October 26, 2011.

Defendant CHS operates and leases more than 130 acute-care hospitals in non-urban markets in 29 states. Defendants Ward Smith and Larry Cash are senior officers of CHS, with Smith serving as Chief Executive Officer and Chairman of the Board, and Cash serving as Chief Financial Officer and Director.

Hospitals admit on an inpatient basis patients who present for treatment while suffering from complex medical conditions that will likely require care for 24 hours or more. Hospitals admit on an outpatient observation basis patients whose medical

condition requires care for less than 24 hours, and whose condition is not so serious that the full spectrum of inpatient services is indicated.

At its facilities, CHS provides both inpatient admission and outpatient observation services. However, its use of observational status prior to 2011 was less than half the national average rate for United States hospitals. This was not a fluke, according to Plaintiffs, because, for at least ten years prior to the filing of the initial complaint, CHS improperly yet systematically boosted its Medicare revenues by admitting patients for inpatient service when all that was medically required was outpatient observation. This resulted in huge earnings as more than 27 percent of CHS' net operating revenue is derived from Medicare reimbursement payments.

Medicare pays more for inpatient treatment than for outpatient observation because the latter requires a shorter hospital stay and typically less testing and monitoring. During the relevant time period, CHS received on average $3,300 (or 257 percent more) from Medicare for a given inpatient admission than for an outpatient observation admission. This point was driven home to the CEO's and physicians at CHS's hospitals in various ways. For example, Michael Miserocchi, Group Operations V.P. and Senior Director of Emergency Department ("ED") programs reminded CEOs that every admission was worth approximately $5,800 in net revenue, while every patient discharged home was worth approximately $250 in net revenue. Similarly, Carolyn Lipp, Senior Vice President of Quality and Resource Management and a direct report to Smith and Cash, gave a 2008 presentation during which

she stated that the maximum reimbursement for observation status was only $661, but Medicare reimbursed hospitals up to $7,000 for admitted patients.

After being made the subject of a hostile takeover attempt by CHS, Tenet Healthcare Corporation ("Tenet") sued CHS on April 11, 2011. It was that suit that served as the impetus for this lawsuit because the complaint publicly revealed that CHS's successful track record of increasing revenues at acquired hospitals was attributable to improper and unsustainable ED admission practices. More specifically, CHS employed practices to drive up Medicare revenues by admitting patients rather than discharging them.

These improper and concealed practices included the lofty goal of zero observations for Medicare patients. To achieve that desired end, CHS used aggressive admission justifications, known as the Blue Book, and programming in CHS's Pro-MED software system. CHS also implemented bonus programs; admission rate quotas approaching 50% for Medicare (over 65 years old) patients; and employment terminations to compel CHS personnel to adhere to the aggressive admissions policy.

B. Blue Book and Pro-MED

Starting in 2000, CHS developed and implemented the Blue Book, a compendium of liberal admissions criteria. The Blue Book did not list an objective treatment criteria but, rather, a series of "Admission Justifications" that would trigger the medical staff to admit patients who otherwise could have been placed in observation and/or released.

The Blue Book was used for patient intake at least until the filing of the Tenet lawsuit, and providers were schooled in its use. For example, in 2004, Lipp prepared a PowerPoint presentation, approved by Smith, that set forth the company-wide protocol applicable to all CHS hospitals: "All physicians should receive a copy of the Blue Book"; "each case manager should carry one with them"; an "[e]lectronic version should be available in ER"; and applicable admission criteria should be placed on the bedside hospital record of every ED patient for review by emergency nurses and physicians. (Docket No. 167, First Amended Complaint ("FAC") ¶ 28).

With observation not being mentioned, observation status was not an option for physicians trained on the Blue Book criteria. The goal, instead was a "ZERO Medicare observation" policy, with Lipp stating, "[w]e want to avoid observation as much as possible on Medicare patients and on private insurance," and issuing a directive to hospital case managers, "no chest patients in observation." (Id. ¶ 29). Indeed, in a training presentation titled "Observation Status and One-Day Stays," Lipp emphasized that "case management MUST BE NOTIFIED of every Observation case and MUST APPROVE the use of observation before the patient is placed into Observation status." (Id.).

The edicts were taken to heart. Steve Grubs, the CEO of Berwick Hospital, informed corporate in a 2006 quarterly report that "the CEO and ER Director will immediately implement the Blue Book Plan or other plan," and would work toward a "goal of ZERO Medicare Observation." (Id. 32). Similarly, the Medical Director of the Emergency Department at

Gadsen Regional Medical Center stated that it was "the CHS" way to admit "just about all our chest pain to inpatient status." (Id. ¶ 31). Likewise, the Phoenixvile Hospital's CEO reported to his division president and other executives that he was "in the ER throughout the day (including weekends)" and made sure ER physicians' "marching orders are to admit." (Id. ¶ 33).

No other hospital chain in the United States used the Blue Book. Instead, the vast majority used independent, third-party admissions criteria provided by InterQual or the Milliman Care Guidelines. The former was developed by a panel of 1,100 healthcare providers and used by 3,700 hospitals; the latter was developed by a team of physicians, reviewed by approximately 100 doctors, and used by over 1,000 hospitals.

In addition to the Blue Book, CHS used Pro-MED, a proprietary networked software system, to track, in real time, patient, ED and individual physician statistics. Performance of hospital, departments, and physicians were compared to each other, and Pro-Med helped to insure that benchmarks were met.

Pro-MED was deployed after CHS acquired Triad hospitals and learned that their ED rates were unacceptably low. This resulted in the loss of approximately $40 million annually in net revenue to Triad.

Smith mandated that Pro-Med be installed in every hospital to increase admissions rather than observation. Moreover, the software was standardized at every hospital and contained a "lock

out" feature that prevented physicians from making changes. All hospitals were to "fully utilize Pro-MED capabilities," including "test mapping,[1] interfaces, [and] status boards." (Id. ¶ 49). Corporate tracked hospitals levels of Pro-MED corporate "standardization," and "how compliant [] ED docs [we]re with the Pro-MED system recommendations for admission." (Id. ¶ 43).

Not only were hospitals required to use Pro-MED, Medical Directors were tasked with reviewing its reports to identify patterns or problems among ED doctors and report those findings weekly to the CEO of the hospital.[2] If patterns of non-admission were discovered, doctors were to be counseled.

At some hospitals, a "QualCheck" feature was installed in the Pro-MED system. This feature identified patients with an "alert" or "flag" in the patient's record and required tests or treatment before the flag could be removed. Physicians who decided to discharge patients despite the flags were required to actively override QualCheck and that override – considered to be "lost revenues" – was identified and tracked by CHS. (Id. ¶ 44). Further, performance metrics were built into contracts with physician groups so that CHS "could restrict the

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[1] Test mapping involved "standardizing a set of minimum tests that are required for patients with certain chief complaints." (Id. ¶ 41). At Smith's direction, the tests ordered for each medical condition were determined, "locked down" at the corporate level, and health care providers who desired to make changes to the feature were required to submit change requests.

[2] Additionally, CEOs were to spend an hour a day in the ED and daily meetings with that department were to be held.

percentage of patients discharged with Pro-MED review flags to 35% of total visits." (Id. ¶ 46)

Many physicians were unhappy that CHS used Pro-MED to supersede their independent medical judgment. One viewed the indicator for some of the flags as "ridiculous." Another stated, that he was aggravated with the use of Pro-MED because doctors felt compelled to justify their decision to discharge a patient. An internal memorandum informed Cash that numerous physicians questioned using "a tool like Pro-MED," and that "Pro-MED was not a good tool in anyone eyes." (Id. ¶ 47).

Some physicians also found that the Pro-MED "test-mapping component" compromised patient safety. In this vein, the Director of Quality Assurance at Watsonville Community Hospital, Michael McGannon, informed CHS senior management in 2007 that Pro-MED's standardized test mapping "subject[s] patients to unnecessary pain, radiation and expense," that the "blanket use of these several tests is contrary to the standard of care," and that "[e]xpecting the triage staff to manipulate chief complaint designations to get around ordering inappropriate tests is, in itself, inappropriate." (Id. ¶ 48). Notwithstanding such concerns, CHS mandated that Pro-MED be used in every hospital and controlled from corporate headquarters.

CHS's headquarters pressured Division Heads, who, in turn, pressured hospital CEOs and staff to use the Blue Book to meet or exceed the benchmarks tracked by Pro-MED. For example, Lockhaven Hospital implemented daily "flash meetings" and produced a "Score Card" to show that they were

keeping up with the benchmarks, and every morning the chief executives there met to discuss emergency room visits and admissions statistics. The CEO of White County Community Hospital, when faced with "the current freefall in our ED admit rate," indicated he was "working on getting the current ED Physicians in line as well as recruiting some replacement physicians who understand the expectations we have for our patients." (Id. ¶ 56).

C. Enforcement of No-Admission Policy

Physicians who had low admit rates, or failed to improve their admit rates, were either terminated, replaced, or had their shifts reduced. Just by way of example, (1) after a 13% decline in admissions, the Action Plan for Skyridge Medical Center was to "eliminate ED physician low performers"; (2) a physician at Lock Haven Hospital who had admissions rates in the single digits "was going to be transitioned from the schedule," and another was terminated for consistently falling below the benchmarks for patients over 65; (3) a "low admitter" at Parkway Regional Hospital was "taken off [the] June [2009] schedule"; and (4) a physician at the Berwick Hospital had his shift reduced because he was a "chronic low admitter." (Id. at ¶ 60).

No only were individual physicians disciplined, entire practice groups were subject to termination. This occurred at the South Texas Regional Medical Center, as well as at the Spokane Deaconess Hospital.

On the other hand, those who performed well, *i.e.* met or exceeded the benchmarks, were rewarded.

This included not only bonuses for CEOs, but also incentive plans for individual doctors.

CHS' standardization and centralization of ED practices through use of the Blue Book and Pro-MED proved highly successful in increasing admissions. A Division II "Executive Summary-September 2008" indicated that for the nine months ending September 30, 2008, 43,009 patients were admitted while only 736 were placed in observation, and that, for those patient over 65, only 23 patients were placed in observation.

When CHS acquired the 50 or so Triad Hospitals in 2007, those hospitals' performance increased as well through the use of the Blue Book, notwithstanding resistance by the CEOs of those hospitals to its implementation. Following implementation of the CHS's protocols, Brownwood Regional Medical Center, a former Triad hospital, reduced weekly observation rates from 20% to 3% over the ten week period from August 29 to October 31, 2007. Overall, within a year of Triad's acquisition, the use of observation status at the former Triad hospitals decreased by 52% through the implementation of Blue Book admission practices, while the percentage of "one-day stay" admissions increased by one-third, with even higher increases for patients with common conditions such as chest pain, syncope (fainting), and gastro-intestinal bleeding.

D. Knowledge of Medicare Compliance Issues

Plaintiff claims that Defendants' misrepresentations were made with full knowledge that the metric used to drive increased admission

likely violated Medicare requirements. This problem, moreover, was known for years from both internal audit review and consulting experts.

In a February 2004 memorandum, Chuck Reece, QRM Regional Director, informed Lipp and CHS's head compliance officer about "evidence of a widespread trend of one-day stays," resulting from CHS's policy of "no Medicare observations" that posed a "significant potential compliance issue relating to the use of observation within our facilities." (Id. ¶ 87). Reece also indicated that he had been informed that the goal of no Medicare observation came from corporate.

Subsequently, the QRM department prepared observation guidelines. Those guidelines, however were rejected by the Regional Physician Advisory Committee on January 8, 2005 because, even though they could be a "useful tool to [the] case manager," such guidelines "could confuse the physicians" and "may prompt physicians to use the observation category instead of admitting the patient to inpatient status when possible." (Id. ¶ 90). The CHS Physician Advisory Board, headed by Smith and Cash, adopted that rationale and, on January 14, 2005, decided to continue excluding observation guidelines from the Blue Book. That exclusion from the Blue Book continued for almost five years.

In 2006 CHS retained Primaris to perform an independent study called the "One-Day Stay Project." The study revealed that 61% of the randomly chosen patient admitted under the Blue Book for one-day stays at Northeast Regional Medical Center during the second half of 2005 failed the InterQual admission criteria for admission, resulting in

additional Medicare payments of $180,600. Another consultant, Health Services Advisory Group, expressed concerns in May 2007 that the Bluebook criteria justifying admission of patients with the Medicare billing code for chest pain "would allow patients who should be categorized as Observation status to be admitted as Inpatient status." (Id. ¶ 93).

Additionally, CHS's own internal audits found that patients were being inappropriately admitted pursuant under the Blue Book. On August 17, 2007, Carol Hendry, a Vice President and Corporate Compliance and Privacy Officer (and a direct report to Smith), prepared a compliance Status Report that indicated 56 of the 72 patients admitted for one-day stays at Chestnut Hills Hospital did not meet admissions criteria. In that same report, Hendry informed Smith that she would provide him with a submission about the "Dr. Joe Zebrowitz issue" the following week.

Dr. Zebrowitz of Executive Health Resources, a longtime expert consultant, was hired by CHS to review its admissions practices. He documented compliance problems at numerous CHS hospitals relating to the Blue Book criteria that resulted in one-day stays, a known Medicare red flag. In his report on Watsonville Community Hospital in 2006 for example, Dr. Zebrowitz noted CHS' serious risk because there were almost no observations and the Centers for Medicare and Medicaid Services ("CMS") was aggressively investigating Medicare fraud with a focus on the red flags for lack of medical necessity. On September 7, 2007, Hendry provided Smith with a summary of Dr. Zebrowitz's investigation.

On January 21, 2008, Dr. Zebrowitz emailed Hendry and reiterated his concerns regarding CHS's medical necessity compliance. Dr. Zebrowitz advised Hendry that he had been retained as an expert witness and consultant in connection with the Office of Inspector General's ["OIG's"] investigation that resulted in a $26 million settlement of claims against St. Joseph Hospital of Atlanta. Attached to the email was a Department of Justice release, that stated the settlement covered claims against St. Joseph's for short stay inpatient admissions, usually of one day or less, which should have been billed on an outpatient observation basis. He went on to write:

> The lesson we took away from the St. Joe example was "Do not get the OIG to investigate you" . . . I think your current processes and underlying basis (such as – we don't really have any observation) place your organization at serious risk.

(Id. at ¶ 99).

On January 30, 2008, Dr. Zebrowitz sent his conclusions to Hendry. Dr. Zebrowitz indicated that, although there is no regulatory requirement that a hospital use a particular commercially available screening criteria such as InterQual, the basis for determining medical necessity must, in accordance with 42 C.F.R. 411.406(e), still comport with either Quality Improvement Organization Guidelines or Local Standards of Care. The Blue Book criteria, however, (1) "lack[ed] specificity, allowing all cases to be classified as inpatient"; (2) would likely be construed as "statistically biased"; (3) results in "overcertification of inpatient"; and (4) could be

construed as "an avoidance of best practices." (Id. ¶ 101).

Dr. Zebrowitz's investigation also revealed that CHS's refusal to use observation status presented a "clear medical necessity compliance risk." He also wrote that CHS instructed case managers "to make everything inpatient," and that

> (1) the ED Director at Chestnut Hill Hospital stated "15% of our admissions are not appropriate, but I was told to make them inpatient" and "not to use observation, except for extended post-surgical care";
>
> (2) the Director of Case Management at Porter Hospital was "told not to use observation" and that "[CHS] Corporate tells us not to use observation, except for extended post-surgical care";
>
> (3) the Director of Case Management at Porter Hospital "was told not to use observation";
>
> (4) one-third of the 24 esophagitis/ gastroenteritis cases reviewed failed to support inpatient admission; and
>
> (5) 55% of the one-day stay cases reviewed at Watsonville Community Hospital failed support inpatient admission.

(Id. ¶ 102).

Dr. Zebrowitz also reported that case managers had "repeatedly expressed their discomfort at following [the no-observation] instructions, creating an environment of clear medical necessity compliance risk and exposure." (Id. ¶ 103). He concluded "the fact that Blue Book is utilized by

these hospitals as a rubber stamp and not a screening tool is a potential problem." (Id).

Smith and Cash were informed of Dr. Zebrowitz's findings and conclusions. Nevertheless, the Blue Book was implemented en masse at former Triad hospitals, and no comprehensive changes were made to provide observation status guidelines for another two and one-half years. During that period, improper admissions under the Blue Book continued, with a February 2009 CMS audit of 40 chest pain patients admitted to Oro Valley Hospital showing that 70% did not meet InterQual criteria for admission, and an early 2011 audit of Dyerburg Hospital showing that only one of 185 patients met the InterQual criteria for admission.

E. Growth and Stock Trading

From 2006 through 2011, CHS pursued a growth by acquisition strategy, increasing the number of hospitals from 77 to 131, increasing the number of beds from 9,117 to 19,695, and more than tripling its net revenues from $4.3 billion to $13.6 billion.[3] During his same period, between 26.8% and 32.0% of CHS's net operating revenue was derived from Medicare reimbursement payments, and it allegedly received up to $306 million from improperly billing Medicare.

Between May 2009 and May 2010, Smith sold 500,000 shares of his stock, receiving a profit of $8,443,908 on those sales. For fiscal year 2011, his

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[3] The bulk of this growth occurred through the July 2007 acquisition of the Triad hospital system for $6.8 billion.

total compensation was approximately $21.6 million, including $3.95 in bonuses and incentive.

Between August 2009 and April 2010, Cash sold 480,000 shares of his CHS stock and received profits totaling $7,432, 100. For fiscal year 2011, his total compensation was approximately $8.6 million, including $1.4 million received in bonuses.

According to Plaintiff, the sale of stock by both Smith and Cash was not happenstance. Smith sold 250,000 shares of CHS stock (yielding $3,267,500 in profits), and Cash sold 240,000 shares (yielding $2,517,600 in profits) after the PAB decided – for the first time in CHS's history – to change the Blue Book to permit observation for low level chest pain, but before that new policy was implemented. Similarly, after the PAB approved adding observation for many other medical conditions, but again before those changes were implemented, Cash sold another 240,000 shares (for $4,809,600 in profits), and Smith sold an additional 250,000 shares (for $5,176,409 in profits).

As noted, Tenet filed a lawsuit against CHS on April 11, 2011. Tenet alleged CHS had "systematically overbill[ed] Medicare and likely other payors as well . . . by causing patients to be admitted to its hospitals unnecessarily when, under standard clinical practice, these patients should have been treated in outpatient observation status." (Id. ¶ 420). Tenet also alleged that the "overstated . . . admissions statistics and trends, revenues, profits, and cash flow . . . has created substantial undisclosed liabilities to Federal and State healthcare programs, private health insurers and patients." (Id.).

When the Tenet lawsuit was filed, CHS stock suffered a 35.8% decline on heavy trading. In fact, the trading volume totaled 44.7 million shares on April 11, 2011. This was the highest volume of trading in CHS's history and the decline in stock price is the largest to date.

CHS repeatedly denied the claims made by Tenet, calling them inaccurate and meritless. Nevertheless, on August 4, 2014, CHS entered into an agreement with the Department of Justice to settle multiple *qui tam* lawsuits for $98.15 million. In those lawsuit it was alleged that CHS "knowingly submitted or caused to be submitted claims for payment to the Government healthcare Programs for certain inpatient admissions . . . that were medically unnecessary and should have been billed as outpatient or observation services." (Id. ¶ 472). More specifically, the Government alleged that from 2005 to 2010, CHS engaged in a deliberate corporate-driven scheme to increase admissions for patients over the age of 65 who sought treatment in the EDs at almost 120 CHS hospitals and then improperly submitted claims for repayment to Medicare, Medicaid, and the Department of Defense's Tricare program in violation of the False Claims Act. As part of the settlement, CHS entered into a Corporate Integrity Agreement ("CIA") with the Department of Health and Human Services and agreed to create a compliance program that addressed and ensured adherence to the requirements of Medicare and other Federal health care programs.

F. Claims in the Complaint

The initial complaint in this Court was filed on May 9, 2011. The complaint was amended on July

13, 2012, and again on October 15, 2015, the last of which raised new allegations about misrepresentations after the filing of the first complaint.

In the now-controlling First Amended and Consolidated Class Action Complaint, Norfolk County, on behalf of itself and all persons or entities who purchased and/or sold the publicly traded securities of CHS from July 27, 2006 through October 26, 2011, brings two claims. Count I is directed at all three Defendants and alleges violations of Section 10(b) of the Exchange Act and Securities Exchange Commission Rule 10b-5. Count II is directed at Smith and Cash and alleges they are liable under Section 20(a) of the Exchange Act for the violations committed by CHS.[4]

The bulk of the allegations in Plaintiff's First Amended Complaint relate to alleged misrepresentations about the basis of CHS's success before the Tenet complaint was filed. Those

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[4] "Because a primary violation of the securities law is an essential element of a § 20(a) derivative claim, a plaintiff who pleads a § 20(a) claim can withstand a motion to dismiss only if the primary violation is pleaded with legal sufficiency." Thompson v. RelationServe Media, Inc., 610 F.3d 628, 635-36 (11th Cir. 2010); see also, ACA Fin. Guar. Corp. v. Advest, Inc., 512 F.3d 46, 67 (1st Cir. 2008) ("The plain terms of section 20(a) indicate that it only creates liability derivative of an underlying securities violation."); In re Rockefeller Ctr. Properties, Inc. Sec. Litig., 311 F.3d 198, 211 (3rd Cir. 2002) (holding that "dismissal of the § 10(b) claims against [the corporation] made it impossible to hold the individual defendants liable under § 20(a)" because "derivative claims under Section 20(a) depend on proof of a separate underlying violation of the Exchange Act").

representations generally fall into three areas as set forth in the following allegations:

> 8. Defendants actively misled investors about the reasons for CHS's success. Defendants touted the "consistent execution of CHS's centralized and standardized operating strategies," its "ED initiatives," and its hospital acquisition strategy as key factors in growing its business. These statements were materially false and misleading in failing to disclose, inter alia, that these strategies depended in large part on utilizing aggressive non-industry admissions criteria that were unsustainable and a substantial Medicare compliance risk. Indeed, once Tenet revealed CHS's improper admissions practices, CHS was forced to concede that it had recently made the decision to discontinue the Blue Book. Lower patient admissions and ED revenues would be reported in October 2011 for the time being, but the truth was still vehemently denied and actively concealed by Defendants.
>
> 9. CHS's "admit" edict was also contrary to CHS's publicly touted "mission" of providing quality patient-centered healthcare. As found by an ethicist from the University of Tennessee College of Medicine a potential loss of income, peer esteem, staff privileges, one's job or even your entire practice group's contract, created powerful pressure at CHS to align medical staff's professional judgment with the hospital's financial interests, creating a conflict for doctors who were to act in patients' interests. Not only that, but over-admitting also compromised

> patient safety. CHS's reports demonstrate that 70% of "hospital acquired conditions" following admission were inflicted upon Medicare patients.
>
> 10. Defendants' representations that CHS hospitals were in substantial compliance with federal, state, and local regulations and standards, were materially false and misleading in failing to disclose long-standing potential Medicare violations at numerous hospitals.

(Id. ¶¶ 8-10).

As for the alleged misrepresentations after the Tenet lawsuit was filed, Plaintiff contends Defendants falsely, yet knowingly, claimed that Tenet's allegations had no merit – labeling them at one point as being "irresponsible" – and falsely asserted that the switch to InterQual criteria would have no material impact on CHS's operations. Such statements were materially false, according to Plaintiff, because past experience showed precisely the opposite, i.e., that admissions suffered when the Blue Book began to include criteria for observation.

II. Standards of Review

In considering a Motion to Dismiss a complaint alleging fraud in violation of federal securities law, three standards of review come into play. Those standards derive from Rules 12(b)(6) and 9(c) of the Federal Rules of Civil Procedure, and from the Private Securities Litigation Reform Act of 1995 ("PSLRA").

First, under Rule 12(b)(6), "all well-pleaded material allegations of the pleadings" are accepted as true, and those allegations must "be sufficient to give

notice to the defendant as to what claims are alleged, and . . . plead 'sufficient factual matter' to render the legal claim plausible, i.e., more than merely possible." Fritz v. Charter Twp of Comstock, 592 F.3d 718, 722 (6th Cir. 2010) (quoting Ashcroft v. Iqbal, 129 S. Ct., 1937, 1949–50 (2009)). In determining whether a complaint sets forth a plausible claim, a court may consider not only the allegations, but "may also consider other materials that are integral to the complaint, are public records, or are otherwise appropriate for the taking of judicial notice." Ley v. Visteon Corp., 543 F.3d 801, 805 (6th Cir. 2008) (citation omitted).

Second, Rule 9(b) requires that "[i]n alleging fraud or mistake, a party must state with particularity the circumstances constituting fraud or mistake." Fed. R. Civ. P. 9(b). "This rule requires a plaintiff: (1) to specify the allegedly fraudulent statements; (2) to identify the speaker; (3) to plead when and where the statements were made; and (4) to explain what made the statements fraudulent." Republic Bank & Trust Co. v. Bear Stearns, 683 F.3d 239, 247 (6th Cir. 2012). "Although 'conditions of a person's mind may be alleged generally,' Fed. R. Civ. P. 9(b), the plaintiff still must plead facts about the defendant's mental state, which, accepted as true, make the state-of-mind allegation 'plausible on its face.'" Id. (quoting, Iqbal, 129 S. Ct. at 1949) (internal quotation marks omitted).

Third, and "[b]olstering this rule of specificity, the PSLRA imposes further pleading requirements." Indiana State Dist. Council of Laborers v. Omnicare, Inc., 583 F.3d 935, 942–43 (6th Cir. 2009) ("Omincare I"). The "complaint must 'specify each statement

alleged to have been misleading,'" along with "the reason or reasons why the statement is misleading,'" and "must 'state with particularity facts giving rise to a strong inference that the defendant acted with the required state of mind.'" Id. In short, "[a] valid claim under Section 10(b) of the Act and Rule 10b-5 'must allege, in connection with the purchase or sale of securities, the misstatement or omission of a material fact, made with scienter, upon which the plaintiff justifiably relied and which proximately caused the plaintiff's injury.'" Zaluski v. United Am. Healthcare Corp., 527 F.3d 564, 571 (6th Cir. 2008) (citation omitted).

III. Application of Law

"Section 10(b) of the Securities Exchange Act of 1934 forbids (1) the 'use or employ[ment] . . . of any . . . deceptive device,' (2) 'in connection with the purchase or sale of any security,' and (3) 'in contravention of' Securities and Exchange Commission 'rules and regulations.'" Dura Pharm., Inc. v. Broudo, 544 U.S. 336, 341 (2005) (quoting, 15 U.S.C. § 78j(b)). "Commission Rule 10b-5 forbids, among other things, the making of any 'untrue statement of a material fact' or the omission of any material fact 'necessary in order to make the statements made . . . not misleading.'" Id. (quoting 17 C.F.R. § 240.10b-5). "In a typical § 10(b) private action a plaintiff must prove (1) a material misrepresentation or omission by the defendant; (2) scienter; (3) a connection between the misrepresentation or omission and the purchase or sale of a security; (4) reliance upon the misrepresentation or omission; (5) economic loss; and (6) loss causation." Stoneridge Inv. Partners, LLC v.

Sci.-Atlanta, 552 U.S. 148, 157 (2008); see also Brown v. Earthboard Sports USA, Inc., 481 F.3d 901, 917 (6th Cir. 2007).

Defendants contend that Plaintiffs fail to sufficiently allege the essential elements of a securities act claim, raising specific arguments in relation to the alleged misrepresentations that preceded the filing of the Tenet lawsuit, and those that followed the filing of that complaint. They also argue that the post-Tenet allegations are untimely. The Court considers the arguments roughly in the order presented by Defendants.

A. Allegations Regarding Public Statements Up to the Filing of the Tenet Complaint

Defendants move for dismissal of the allegations regarding statements made prior to the filing of the Tenet lawsuit on three primary grounds. First, they contend that the First Amended Complaint does not adequately allege any actionable misrepresentations prior to April 11, 2011. Second, they argue that Plaintiff fails to plead facts giving rise to a strong inference of scienter. Third, Defendants contend that Plaintiff fails to plead that the decline in stock prices when the Tenet lawsuit was filed was caused by any alleged fraud.

1. Actionable Misrepresentations

Defendants note that in the First Amended Complaint, Plaintiff alleges a series of misrepresentations regarding CHS's "business strategy," "operating strategies," "growth strategies," "acquisition strategy," "revenue strategies," "ER strategy," and the like. They characterize the "nub of Plaintiff's claim [to be] that all of these statements

were misleading because *they failed to disclose* that CHSI's business strategies depended, in part, on admissions criteria that were unsustainable and a substantial Medicare compliance risk." (Docket No. 178 at 11, emphasis in original). Defendants insist that CHS's statements attributing its performance to a "business strategy are not actionable, as a matter of law" because (1) CHS "had no duty to opine on whether that strategy presented legal risks"; (2) "Defendants' touting of [CHS's] 'synergies,' 'efficiencies,' and other business-school jargon is immaterial to a reasonable investor, and therefore created no duty to disclose"; and (3) "Defendants did disclose information regarding ED admissions initiatives and risks that Plaintiff faults them for failing to disclose." (Id.).

A company is not required to divulge to the public each tidbit of information it possesses "because corporations might otherwise 'face potential second-guessing in a subsequent disclosure suit,' a regime that would threaten to 'deluge investors with marginally useful information, and would damage corporations' legitimate needs to keep some information non-public.'" City of Monroe Emp. Ret. Sys. v. Bridgestone Corp., 399 F.3d 651, 669 (6th Cir. 2005) (citations omitted). Thus, "[i]n order to be actionable, a misrepresentation or omission must pertain to material information that the defendant had a duty to disclose, id., and generally this duty does not apply to forecasts, or soft information. Zaluski, 527 F.3d at 571.

In this regard, Defendants point out the "black-letter law" that "'[s]ilence, absent a duty to disclose, is not misleading under Rule 10b–5a' Basic Inc. v.

Levinson, 485 U.S. 224, 239 n.17 (1988)," and note that "the Sixth Circuit has made clear that "companies have no duty to opine about the legality of their own actions," because "[s]uch information is considered 'soft,' and, therefore, disclosure is not required." Omnicare I, 583 F.3d at 945." (Docket No. 178 at 12). They then argue that "Plaintiff tries to wordsmith around that dispositive obstacle by repeatedly calling CHSI affiliates' admissions practices 'unsustainable' instead of labeling them 'illegal[.]'" (Id.).

CHS has engaged in a bit of wordsmithing itself, however. In between the phrases excerpted by Defendants from Omnicare I, the Sixth Circuit, in response to the assertion that statements regarding "legal compliance" are not actionable, wrote that, "[a]s a general matter, that is true." Id. The essence of Plaintiff's complaint in this case is not simply that Defendants misled investors about its legal compliance. Moreover, simply characterizing a statement as either being forward-looking or soft, does not mean that liability cannot attach because "[w]hen a company chooses to speak, it must 'provide complete and non-misleading information.'" Omnicare I 583 F.3d at 941 (citation omitted). Thus, "if a company chooses to disclose information about the future, 'its disclosure must be full and fair, and courts may conclude that the company was obliged to disclose additional material facts to the extent that the volunteered disclosure was misleading.'" Zaluski, 527 F.3d at 572. "[E]ven with 'soft information,' a defendant may choose silence or speech based on the then-known factual basis, but it cannot choose half-truths." In re Ford Motor Co. Securities Litig., 381 F.3d at 569.

"When an alleged misrepresentation concerns 'soft information' which 'includes predictions and matters of opinion,' . . . a plaintiff must additionally plead facts showing that the statement was 'made with knowledge of its falsity[.]'" In re Omnicare, Inc. Sec. Litig., 769 F.3d 455, 470 (6th Cir. 2014) ("Omnicare II"). Plaintiff has fulfilled the requirement in this case.

The underlying premise of the First Amended Complaint is that while Defendants touted CHS's "ED initiatives," its "growth by acquisition strategy," and its "consistent execution of CHS's standardized operating strategies" as key factors in the growth of its business, CHS neglected to disclose mandated, non-compliant ,and unsustainable companywide practices that drove that success, and made those misrepresentations with full knowledge that the Blue Book's guidelines were not defensible. Cases like In re Sofamor Danek Group, Inc., 123 F.3d, 394, 400 (6th Cir. 1997) and In re Almost Family, Inc. Securities Litigation, 2012 WL 443461 (W.D. Ky. Feb. 10, 2012) which Defendants characterize as rejecting the same misrepresentation theory on which Plaintiff relies, are inapposite.

In re Sofamor contained allegations that a medical-device company's revenues and success were attributed "to such things as increased sales volume without properly explaining how the sales were being achieved." 123 F.3d at 400. In Defendants' view, "the Sixth Circuit squarely rejected that argument, noting that the plaintiffs – like Plaintiff here – never challenged the accuracy of the sales figures," and " went on to hold that defendants were under no obligation to disclose exactly how they

arrived at those sales figures – namely, by 'engaging in illegal promotion of its products.'" (Docket No. 178 at 12-13, quoting, id. at 401). Even though that may be a proper characterization of the case, the holding was rendered in an entirely different context.

The allegation in In re Sofamor that the company was involved in the illegal promotion of its product had to do with funding a foundation and allowing its sales representatives to attend operations where surgeons made attachments to the pedicle in contravention of a Food and Drug Administration ("FDA") warning. However, the company disclosed its receipt of the warning letter and, while it may have downplayed the warning in its discussion with analysts, "any analyst could easily obtain a copy of the letter and could make an independent judgment of its significance." Id. at 402. Moreover, "[e]ach of the company's 10-K forms explicitly mentioned the risk that the FDA might obtain an injunction[.]" Id.

No such revelations were made in this case. Rather, at least according to the allegation in the First Amended Complaint, CHS hid core facts about the basis for the excessive ED admissions, all the while touting its success. A reasonable investor could certainly view such non-disclosures as important to their investing decisions since, when the facts are viewed in Plaintiff's favor, it was an all but foregone conclusion that the aggressive growth strategies would tank when use of the Blue Book – which no other hospital used – was subjected to scrutiny.

In re Almost Family found that statements about a company's "strategy, success, and management" were not misleading, even where

plaintiff attributed the company's growth to a scheme to manipulate Medicare's reimbursement system. As Defendants in this case note, the court held that where a company's success could be attributed to several factors, the company was not required to discuss all of the factors which lead to the success, particularly since plaintiff did not show that the factors discussed were not "farcical." 2012 WL 443461, at *7.

The court in In re Almost Family did not end its discussion on that point, however. Rather, it observed that individual defendants may have a duty "to disclose even so-called soft information," such as when "the defendants knew of the illegal nature of their conduct at the time they made the allegedly material misstatement." Id. Moreover, the court observed that it was incumbent upon a plaintiff to set forth "a clear allegation that the defendants knew of the scheme and its illegal nature at the time they stated the belief that the company was in compliance with the law[,]'" id. (quoting Kushner v. Beverly Enters., Inc., 317 F.3d 820, 831 (8th Cir.2003), but that simply was not the case where plaintiff relied upon statements of confidential witnesses and a paragraph from a five page resignation letter, none of which "reflect[ed] on Individual Defendants or their actual knowledge of any fraud occurring" within the company. Id. The allegations here are, of course markedly different, with the claim being that the two individual Defendants spearheaded the "zero admissions" policy with knowledge that Medicare would likely take issue with the Blue Book.

Moreover, the court in In re Almost Family distinguished City of Monroe, *supra*, which involved

allegations of securities fraud against a tire manufacturer. There, the Sixth Circuit found that statements like the company's tires were "the best tires in the world," that it had "no reason to believe there is anything wrong with" the tires, and that its successful sales were due to "high regard among automakers for our strengths in product quality," were "best characterized as loosely optimistic statements insufficiently specific for a reasonable investor to 'find them important to the total mix of information available.'" Id. at 671 (quoting In re Ford Sec. Litig., 381 F.3d 563, 570–71 (6th Cir. 2004)). However, noting that "the context of the statement is often telling," the court found that a press release which stated the "objective data clearly reinforces our belief that these are high-quality, safe standards" could, "without some qualification or accompanying disclosure of the numerous pieces of evidence that tended to cut the other way[,]" be viewed by a reasonable jury as a misrepresentation, particularly since there were internal memos that indicated significant problems with certain tires that were failing at "unprecedented rates." Id. at 672-73. In so ruling, the Sixth Circuit emphasized that the decision was being made in the context of a motion to dismiss and cited several cases as support for the conclusion that the company's "representation concerning 'objective data' could be deemed a material misrepresentation by a reasonable fact-finder." Id. at 673. These include Hanon v. Dataproducts Corp., 976 F.2d 497, 502 (9th Cir. 1992), which held "that the defendants' statements emphasizing superior quality were material because a 'reasonable jury could conclude that [the company] publicly released optimistic statements . . . when it

knew [its product] could not be built reliably'" and In re F & M Distribs. Inc. Sec. Litig., 937 F. Supp. 647, 653 (E.D. Mich. 1996), which held "that the defendant chain store's failure to disclose an adverse industry trend that made the 'deal buying' strategy touted in its prospectus less viable than otherwise known could be actionable." Id. In the Court's view, touting an unsustainable and allegedly unlawful admissions practice is akin to touting a less than viable business strategy, or saying that a product can be reasonably built when it is known that it cannot be.

Nor can the statements attributed to Defendants about ER initiatives and increased admissions be swept away as immaterial because they were mere puffery or hyperbole. In Omnicare II, on which Defendants rely, the Sixth Circuit cautioned that a court "must tread lightly at the motion-to-dismiss stage," as "the federal judiciary has a limited understanding of investor behavior and the actual economic consequences of certain statements." 769 F.3d at 471. It also observed that "[t]he purpose of 'the materiality requirement is not to attribute to investors a child-like simplicity, an inability to grasp the probabilistic significance of [opinion statements], but to filter out essentially useless information that a reasonable investor would not consider significant, even as part of a larger 'mix' of factors to consider in making his investment decision.'" Id. at 471-72 (quoting Basic, Inc. v. Levinson, 485 U.S. 224, 234 (1988)). "[A] 'fact is material if there is a substantial likelihood that a reasonable shareholder would consider it important in deciding how to vote.'" Id. at 472. Certainly, a reasonable investor could find it important that the very basis on which the

trumpeted ER success was based on a business model that would collapse.

True, and as Defendants point out, "'public companies praise their products and their objectives.'" (Docket No. 178 at 15, quoting In re Ford, 381 F.3d at 570). Indeed, "[c]ourts everywhere 'have demonstrated a willingness to find immaterial as a matter of law a certain kind of rosy affirmation commonly heard from corporate managers and numbingly familiar to the marketplace – loosely optimistic statements that are so vague, so lacking in specificity, or so clearly constituting the opinions of the speaker, that no reasonable investor could find them important to the total mix of information available.'" In re Ford, 381 F.3d at 570-71 (quoting Shaw v. Digital Equip. Corp., 82 F.3d 1194, 1217 (1st Cir.1996)). Nevertheless, and as already noted, the "securities laws . . . require an actor to 'provide complete and non-misleading information with respect to the subjects on which he undertakes to speak.'" City of Monroe, 399 F.3d at 670. Thus, while a company may not be required "to denigrate its own product, . . . Rule 10b-5 imposes a duty to disclose material facts that are necessary to make disclosed statements, whether mandatory or volunteered, not misleading." Hanon, 976 F.2d at 503.

Here, Defendants attributed their growth success to ED initiatives, but did so without disclosing a potential serious flaw with the very reason for that success. Although they did "not have a Rule 10b-5 duty to speculate about the risk of future investigation or litigation," once they "put the topic of the cause of [CHS's] financial success at issue," they were "obligated to disclose information

concerning the source of the success," and "the alleged failure to disclose the true source of this revenue could give rise to liability under § 10(b)." Sapssov v. Health Mgmt. Assoc., Inc., 22 F. Supp. 3d 1210, 1227 (M.D. Fla. 2014), aff'd, 608 F. App'x 855 (11th Cir. 2015); see also In re Gentiva Sec. Litig., 932 F. Supp. 2d 352, 368 (E.D.N.Y. 2013) (citation omitted) ("The Court has no doubt that information relating to Gentiva's purported push to provide medically unnecessary services to secure extra reimbursement from Medicare, even if only accounting for a small percentage of Gentiva's actual profits, was not 'so obviously unimportant to a reasonable investor that reasonable minds could not differ on the question of their importance.'").

Defendants next argues that, in any event, the statements they made were not misleading because they actually disclosed the risks that Plaintiffs claim they concealed. More specifically, Defendants assert:

> CHSI expressly – and repeatedly – warned investors of the Company's exposure to "heightened coordinated civil and criminal enforcement efforts" relating to "the health care industry," including investigations related to "billing practices." . . . CHSI also warned investors about potential lawsuits under the federal False Claims Act, . . . and that "[s]ettlements of suits involving Medicare and Medicaid issues routinely require both monetary payments as well as corporate integrity agreements," . . . "If we fail to comply with extensive laws and government regulations, including fraud and abuse laws," Defendants explained, "we could suffer penalties or be

> required to make significant changes to our operations." . . .
>
> What is more, Defendants also repeatedly disclosed that a core part of the business strategy of CHSI and its affiliates was their "Emergency Room Initiatives" to "systematically take steps to increase patient flow in our ER as a means of optimizing utilization rates for our hospitals." . . . Indeed, one of the "steps" specifically disclosed was "the implementation of specialized computer software" – i.e., Pro-MED – "designed to assist physicians in making diagnoses and determining treatments." . . . Defendants also told investors that CHSI-affiliated hospital's admission growth was "higher than anybody else['s] in the country," . . . that their "ER Strategy has contributed to same store admission growth," . . . that "CHS reported a 16.9% increase in total inpatient admissions," . . . and that, over a dozen years, "the admission rate out of ER" had increased from 11% to 15%.

(Docket No. 178 at 16-17). In short, because "Defendants told investors that CHSI was pursuing a business strategy of increasing admissions through the ED in an environment in which intense regulatory scrutiny of 'billing practices' made Medicare claims for inpatient admissions vulnerable to regulatory scrutiny . . . In light of those risk disclosures, no reasonable investor could have been misled by Defendants' other statements into thinking those risks did not exist." (Id. at 17).

No doubt, from the disclosures made, investors were forewarned about the general risks involved when claims are made to Medicare, assuming they

placed any stock in such disclosures. Plaintiff's argument is more nuanced, however. It claims that Defendants failed to point out the known risks because of the use of the Blue Book and the fact that the practice was unsustainable.

Contrary to Defendants' argument, the Sixth Circuit decision in Bondali v. Yum! Brands, 620 F. App'x 483 (6th Cir. Aug. 20, 2014) does not bar such a claim. That case involved the assertion that it was false and misleading for Yum food brands to state that food safety issues "have occurred in the past, and could occur in the future," when it knew (prior to exposés in the press) that batches of chicken being supplied to its KFC China subsidiary had tested positive for drug and antibiotic residues. Id. at 491 (citations omitted). While the Sixth Circuit observed that "several courts have concluded, 'cautionary statements are not actionable to the extent plaintiffs contend defendants should have disclosed risk factors 'are' affecting financial results rather than 'may' affect financial results," and that there is a "good reason" for this conclusion because "[r]isk disclosures like the ones accompanying 10-Qs and other SEC filings are inherently prospective in nature," it also opined "there may be circumstances under which a risk disclosure might support Section 10(b) liability [but] this is not that case." Id. It was not the case in Bondali because plaintiffs failed to allege that the problems of the two suppliers of bad chicken "were so severe that they would have resulted in financial loss for Yum" – "eight batches of chicken testing positive for drug and antibiotic residues is hardly a companywide food safety epidemic." Id.

Here the allegations are quite different. The allegations, when construed in Plaintiff's favor, suggest that a huge reasons for the ED success had to do with sketchy admission/no observation policies about which Defendants had been repeatedly warned, but did not disclose. "[C]ertainly a company could have enough internal information to know that it had severe compliance issues." Omnicare II, 769 F.3d at 480.

Based on the foregoing, the Court finds the allegations regarding CHS' operating and admissions strategies, its emergency room initiatives, and its substantial compliance with Medicare as summarized in paragraphs 8 and 10 of the First Amended Complaint meet the requirements of material misrepresentations or omissions for purposes of the first element of a securities fraud claim and are sufficiently pled. The Court reaches the opposite conclusion, however, with respect to Defendants' touting of its quality patient care as summarized in paragraph 9.

In paragraph 9, Plaintiff alleges that CHS's purported mission of "providing quality patient-centered healthcare" was false because the "admit" edict led to admissions and treatment that were not necessary. Even if this is true, Plaintiff does not explain how a reasonable investor would be mislead into making an investment decision based on such statements. Presumably most, if not all hospitals, for profit or not, claim to be dedicated to taking care of their patients. This seems to be the very essence of corporate hyperbole or puffery. See, Intermountain Stroke Ctr., Inc. v. Intermountain Health Care, Inc., 2016 WL 523613, at *7 (10th Cir. Feb. 9, 2016)

(hospital's claim "to identify and implement best medical practices at the lowest available cost" is "emblematic of sales puffery"); Corley v. Rosewood Care Ctr., Inc. of Peoria, 388 F.3d 990, 1008-09 (7th Cir. 2004) (in wire fraud case against nursing home, court noted that the "phrase 'high quality' is highly subjective" and that "[w]ithout elaboration, it comes under the category of sales puffery upon which no reasonable person could rely in making a decision and therefore it does not qualify as material"); Maio v. Aetna Inc., 1999 WL 800315, at *2 (E.D. Pa. Sept. 29, 1999) ("as a matter of law, it is highly doubtful that advertising one's commitment to 'quality of care' can serve as the predicate for a fraud claim").

2. Scienter

"In run-of-the-mill fraud cases," a plaintiff can allege the requisite "mental state 'generally,' Rule 9(b), but in securities-fraud actions, Congress has imposed a higher standard, requiring plaintiffs to 'state with particularity facts giving rise to a strong inference that the defendant acted with the required state of mind,'" Omnicare II, 769 F.3d at 472-73 (quoting 15 U.S.C. § 78u-4(b)(2)).[5] Relying on the Supreme Court's decision in Tellabs, Inc. v. Makor Issues & Rights, Ltd., 551 U.S. 308, 322-23 (2007), the Sixth Circuit has summarized the "three-part

[5] Where an individual's mental state is at issue, the analysis is relatively straightforward, but the analysis for corporate scienter can be "complicated." Id. at 473. Here, because Plaintiff attributes virtually all of the alleged misstatements or omission to Smith and Cash, Defendants acknowledge that those individual's mental states are the ones at issue.

test for lower courts to apply in determining assessing plaintiff's scienter allegations":

> First, a court must "accept all factual allegations in the complaint as true." . . . Second, a court must consider the complaint in its entirety" and decide "whether all of the facts alleged, taken collectively, give rise to a strong inference of scienter, not whether any individual allegation, scrutinized in isolation, meets that standard." . . . Third, assuming that plaintiff's allegations create a "powerful or cogent" inference of scienter, . . . , a court must compare this inference with other competing possibilities, allowing the complaint to go forward "only if a reasonable person would deem the inference of scienter cogent and at least as compelling as any opposing inference one could draw from the facts alleged[.]

Omincare II, 769 F.3d at 473 (internal citations to Tellabs omitted).

Defendants argue that Plaintiff fails to "plead facts that give rise to a strong inference that Smith or Cash (and by extension, CHS) 'knowingly' misrepresented material facts with the specific intent 'to deceive, manipulate, or defraud the public'" because (1) all that is alleged is that Smith and Cash sold stock after changes in the Blue Book were made, but before they became public; and (2) with "threadbare allegations" Plaintiff contends that Smith and Cash personally focused on admissions. (Docket No. 178 at 21). The former fails, Defendants assert, because, in accordance with Konkol v. Diebold, 590 F.3d 390, 399 (6th Cir. 2009), to raise an inference of scienter, "plaintiffs must provide a

meaningful trading history for purposes of comparison to the stock sales within the class period." The latter fails, according to Defendants, because "the essence of the duty of loyalty" for executives of a for-profit hospital is to earn profits, quoting ECA, Local 134 IBEW v. JP Morgan Chase Co., 553 F.3d 187, 200 (2nd Cir. 2009). In the Court's opinion, Defendant's citation to the case law is too cabined and they read Plaintiff's allegations too narrowly.

As Defendants' claim, the Sixth Circuit in Konkol noted the requirement for a trading history to show scienter. But it also observed that "'[i]nsider trading at a suspicious time or in an unusual amount' is one of the nine factors 'usually relevant to scienter' that this court first applied in Helwig v. Vencor, Inc., 251 F.3d 540, 552 (6th Cir. 2001)." Konkol, 590 F.3d at 399. This point was confirmed in Omincare II, where the Sixth Circuit wrote that, with regard to the knowledge of an individual, a court should consider various factors, such as whether there was:

> (1) insider trading at a suspicious time or in an unusual amount; (2) divergence between internal reports and external statements on the same subject; (3) closeness in time of an allegedly fraudulent statement or omission and the later disclosure of inconsistent information; (4) evidence of bribery by a top company official; (5) existence of an ancillary lawsuit charging fraud by a company and the company's quick settlement of that suit; (6) disregard of the most current factual information before making statements; (7) disclosure of accounting

> information in such a way that its negative implications could only be understood by someone with a high degree of sophistication; (8) the personal interest of certain directors in not informing disinterested directors of an impending sale of stock; and (9) the self-interested motivation of defendants in the form of saving their salaries or jobs.

Omnicare II, 769 F.3d at 473 (quoting Helwig, 251 F.3d at 552).

Moreover, Konkol was decided before Matrixx Initiatives, Inc. v. Siascusano, 131 S. Ct. 1309 (2011), at a time when the Sixth Circuit "conducted [its] scienter analysis in section 10(b) cases by sorting through each allegation individually before concluding with a collective approach." Frank v. Dana Corp., 646 F.3d 954, 961 (6th Cir. 2011). Discussing the change, the Sixth Circuit in Frank observed that in Matrixx,

> the Court provided for us a post-Tellabs example of how to consider scienter pleadings "holistically" in section 10(b) cases. . . . Writing for the Court, Justice Sotomayor expertly addressed the allegations collectively, did so quickly, and, importantly, did not parse out the allegations for individual analysis. . . . This is the only appropriate approach following Tellabs's mandate to review scienter pleadings based on the collective view of the facts, not the facts individually. . . . Our former method of reviewing each allegation individually before reviewing them holistically risks losing the forest for the trees. Furthermore, after Tellabs,

> conducting an individual review of myriad allegations is an unnecessary inefficiency.

646 F.3d at 961 (internal citations and quotations omitted).

Thus, it falls on the Court to "decide whether all of the facts alleged, *taken collectively*, meet the PSLRA's requirements," and whether there is a "strong inference" of fraudulent intent, that is, fraudulent intent that is "'more than merely plausible or reasonable—it [is as] cogent and at least as compelling as any opposing inference of nonfraudulent intent.'" Ashland, Inc. v. Oppenheimer & Co., Inc., 648 F.3d 461, 469 (6th Cir. 2011) (italics in original) (quoting, Tellabs, 551 U.S. at 314). That strong inference exists in this case.

Smith and Cash both profited handsomely from the sale of stock an opportune time. This occurred not once, but twice. Both ditched stock after learning, from their roles on the Physician Advisory Board, that observation was going to be included in the Blue Book. Maybe this occurred on two separate occasions by two individuals for entirely innocuous reasons. But the Court cannot ignore the numerous allegations that Smith and Cash were the driving force behind increased admissions, all the while concealing these practices in touting CHS's success. Among other things, it is alleged that Smith and Cash (1) supervised the implementation of the Blue Book and its training at all CHS hospitals in order to improperly convert observations into admissions; (2) assured admissions by using a "no observation" policy; (3) implemented Pro-Med's Test Mapping and QualCheck features, and tracked compliance by doctors; (4) awarded incentive bonuses to hospitals'

CEOs and ED staff for meeting the benchmark admissions percentages, while terminating or changing the schedules of physicians who failed to meet benchmarks; and (5) were repeatedly told their admissions practices gave rise to Medicare violations.

Defendants argue that "[*o*]*f course* Smith and Cash, as executives of a for-profit hospital operator, focused on admissions (among other things) to drive CHSI's stock value, and point out that "'[e]arning profits for the shareholders is the essence of the duty of loyalty, and therefore it would be an unusual case where accomplishment of this objective constitutes the requisite motive to defraud the shareholders.'" (Docket No. 178 at 22, emphasis in original) (quoting ECA, Local 134 IBEW Joint Pension Trust of Chicago v. JP Morgan Chase Co., 553 F.3d 187, 200 (2nd Cir. 2009)). But the essence of the allegations in this case are that Smith and Cash focused on fraudulent admissions and benefitted from that practice. Misleading investors and bilking Medicare until caught is not in the interest of interest of shareholders. In any event, "where two equally compelling inferences can be drawn, one demonstrating scienter and the other supporting a nonculpable explanation, Tellabs instructs that the complaint should be permitted to move forward." Frank, 547 F.3d at 571.

3. Causation

A claim under Section 10(b) and Rule 10b-5 requires proof of "the traditional elements of causation and loss." Dura, 544 U.S. at 346. "To plead loss causation, plaintiffs must allege 'that the subject of the fraudulent statement or omission was the

cause of the actual loss suffered,'" and "may do so either by alleging (a) 'the existence of cause-in-fact on the ground that the market reacted negatively to a corrective disclosure of the fraud;' or (b) that 'that the loss was foreseeable and caused by the materialization of the risk concealed by the fraudulent statement.'" Carpenters Pension Trust Fund of St. Louis v. Barclays PLC, 750 F.3d 227, 232-33 (2nd Cir. 2014) (citations omitted).

In this case, Plaintiff proceeds on a "fraud on the market theory" and pegs loss causation on the fact that, after the Tenet lawsuit was filed, the value of CHS's stock dropped dramatically. Defendants argue this is an insufficient basis on which to base loss causation for two reasons – the Tenet complaint raised allegations of fraud that were not "new," and the filing of a complaint is not a corrective disclosure. While the first argument has some facial appeal, the Court finds the second argument to be dispositive.

"Loss causation is 'easiest to show when a corrective disclosure reveals the fraud to the public and the [company's share] price subsequently drops.'" In re KBC Asset Mgmt. N.V., 572 F. App'x 356, 360 (6th Cir. 2014) (quoting, In re Williams Sec. Litig.-WCG Subclass, 558 F.3d 1130, 1137 (10th Cir. 2009)). However, such a theory only works when a 'disclosed fact [is] . . . new to the market.'" Id. (quoting In re Omnicom Grp., Inc. Sec. Litig., 541 F. Supp. 2d 546, 551 (S.D.N.Y. 2008). "'Corrective disclosures must present facts to the market that are new, that is, publicly revealed for the first time, because, if investors already know the truth, false statements won't affect the price.'" Rand-Heart of New York, Inc. v. Dolan, 812 F.3d 1172, 1180 (8th

Cir. 2016) (quoting Katyle v. Penn Nat. Gaming, Inc., 637 F.3d 462, 473 (4th Cir. 2011)).

Defendants argue that the Tenet lawsuit merely presented that which was already publicly available. This is shown by the allegations in the Tenet complaint itself, which stated that "[t]he information set forth in this Complaint is based on public information relating to Medicare patients alone." (Docket No. 83-3, Tenet Complaint ¶ 4 fn. 2). Similarly, the First Amended Complaint in this case alleges that the Tenet suit was based on "available data from CMS." (Docket No. 167, FAC ¶ 189).

Further, in the Consolidated Class Action Complaint in this Court (now superseded by the First Amended Complaint), Plaintiff alleged that "these same allegations of improper admissions practices were raised in [a] *Qui Tam* Action", (Docket No. 68 Consolidated Complaint ¶ 31) styled United States *ex rel.* Reuille v. Community Health Sys., Case No. 1:09-CV-007 (N.D. Ind. 2009). That suit was unsealed on December 27, 2010, more than three month before Tenet filed its suit.

Defendants also point to a letter from the Service Employees International Union to a Dr. Solhanki. That letter cited several false claims cases that had been filed, and detailed concerns about the ER initiative given that "doctors and staff have accused CHS management of coercing them to admit patients unnecessarily, and firing those who object." (Docket No. 179-1).

As noted, Defendant's first argument has some appeal, but the Court agrees with Plaintiff that whether the allegations in the Tenet lawsuit were

new raises a factual question. While this Court can take judicial notice of documents filed in court, the letter from the union is an altogether different matter and is even more problematic since it does not appear that it was publicly disseminated.

As for the Tenet Complaint, even though Plaintiff alleged that it was based on "available data from CMS," it also alleged that Tenet "retained two 'leading' healthcare consulting firms" to study the data, which, in turn, conducted "statistical analyses" of the data. (Docket No. 167, FAC ¶ 189-190). "[R]aw data itself" that may be "technically available to the public" may have "little to no probative value in its native state":

> While it is generally true that in an efficient market, any information released to the public is presumed to be immediately digested and incorporated into the price of a security, it is plausible that complex economic data understandable only through expert analysis may not be readily digestible by the marketplace. Under a Rule 12(b)(6) analysis, it is plausible that . . . the efficient market was not aware of the hidden meaning of the Medicare data that required expert analysis, especially where the data itself is only available to a narrow segment of the public and not the public at large.

Pub. Emp. Ret. Sys. of Miss., Puerto Rico Teachers Ret. Sys. v. Amedisys, Inc., 769 F.3d 313, 323 (5th Cir. 2014).

Reuille presents a closer question because the complaint there raised numerous allegations about

improper Medicare billing, including false 23-hour observation billing and the intentional assignment of inpatient status where such status was unwarranted so as to receive more reimbursement from Medicare even though the patients did not require such care. But the allegations were directed a one hospital, specifically the Lutheran Hospital in Fort Wayne, Indiana. It is unclear whether that information should be considered publicly available because, as the Supreme Court has explained, "[t]he markets for some securities are more efficient than the markets for others, and even a single market can process different kinds of information more or less efficiently, depending on how widely the information is disseminated and how easily it is understood." Halliburton Co. v. Erica P. John Fund, Inc., 134 S. Ct. 2398, 2409 (2014). "[M]arket efficiency is a matter of degree and accordingly . . . a matter of proof." Id. at 2410.

New information or not, loss causation is "context dependent," Miller v. Thane, Int'l, Inc., 615 F.3d 1094, 1102 (9th Cir. 2010). Nevertheless, many courts have held that loss causation (sometimes called a "loss event") cannot be based on the filing of a civil complaint or the commencement of an investigation. The theory undergirding such holdings is that allegations of fraud do not reveal a previously undisclosed truth. See In re Almost Family , 2012 WL 443461, at *13 ("Numerous federal district courts have held that a disclosure of an investigation, absent an actual revelation of fraud, is not a corrective disclosure").

Most analogous in this regard is Sapssov v. Health Management Associates, Inc., 608 F. App'x

855 (11th Cir. 2015). There, plaintiffs alleged that HMA (which also used Pro-Med Software in its emergency departments "to control physicians and increase patient admissions by ordering an extensive series of tests") "devised a corporate policy mandating unnecessary admission of Medicare patients to HMA hospitals to boost its financial position and stock price." Id. at 857. It was also alleged that "HMA admitted patients for observation, when they did not need to be admitted, and admitted inpatients, who should have been admitted for observation." Id. Based on factual allegations quite similar to those in this case, the district court concluded that (1) plaintiffs "had satisfied the PLSRA heightened pleading requirements"; (2) plaintiffs "had 'sufficiently plead the false and misleading statements' to show material misrepresentation . . . based on particularized allegations"; (3) because defendant "'put the source of HMA's success at issue, the alleged failure to disclose the true source of this revenue could give rise to liability under § 10(b)'"; and (4) the allegations (including "aggressive admissions policies," "heavy involvement in daily operations," "'the upgrade of Pro-MED software,'" and the "widespread nature of the fraud") "when viewed holistically create[d] a strong inference of scienter.'" Id. at 861 (citations omitted). Nevertheless, plaintiff's securities fraud complaint failed on the loss causation element because the commencement of an investigation did not constitute a corrective disclosure, and "[t]he filing of a civil complaint certainly does not establish that the defendant committed or is liable for the conduct alleged." Sappsov v. Health Mgmt. Assoc., Inc., 22 F. Supp. 3d 1210, 1230 (M.D. Fla. 2014).

On appeal, the Eleventh Circuit "agree[d] with the district judge's analysis regarding the second-amended complaint as to particularity, material misrepresentation, and scienter reflected in the purchase and sale of HMA stock." Id. It also agreed with the trial court's conclusion on loss causation, noting that "[r]evelation of the OIG investigation, including issuance of subpoenas, does not show any actual wrongdoing and cannot qualify as a corrective disclosure." Id. at 863. Moreover, the filing of a "whistleblower case" which served as the basis for an equity analyst's report "was not proof of fraud, because a civil suit is not proof of liability." Id.

Obviously, Sapssov is not controlling authority. Not only is it out-of-circuit, it is unpublished and subject to a petition for rehearing to boot. However there is published appellate authority for the proposition that an investigation is insufficient to be a corrective disclosure and, while not from the Sixth Circuit, the Court finds that authority persuasive.

Sappsov's conclusion about an investigation not being a corrective disclosure was based on Meyers v. Greene, 710 F.3d 1189 (11th Cir. 2013), an earlier Eleventh Circuit case. There, the court noted that a plaintiff can "go about proving loss causation . . . by: '(1) identifying a "corrective disclosure (a release of information that reveals to the market the pertinent truth that was previously concealed or obscured by the company's fraud); (2) showing that the stock price dropped soon after the corrective disclosure; and (3) eliminating other possible explanations for this price drop, so that the factfinder can infer that it is more probable than not that it was the corrective disclosure – as opposed to other possible depressive

factors – that caused at least a substantial amount of the price drop.'" Id. at 1196-97 (quoting FindWhat, 658 F.3d at 1311-12). The Eleventh Circuit went on to hold:

> In our view, the commencement of an SEC investigation, without more, is insufficient to constitute a corrective disclosure for purposes of § 10(b). The announcement of an investigation reveals just that – an investigation – and nothing more. . . . To be sure, stock prices may fall upon the announcement of an SEC investigation, but that is because the investigation can be seen to portend an added risk of future corrective action. That does not mean that the investigations, in and of themselves, reveal to the market that a company's previous statements were false or fraudulent.

Id. at 1201 (internal citation omitted). In an accompanying footnote, the court further observed:

> That is not to say that an SEC investigation could never form the basis for a corrective disclosure. We merely hold that the disclosure of an SEC investigation, standing alone and without any subsequent disclosure of actual wrongdoing, does not "reveal[ ] to the market the pertinent truth" of anything, and therefore does not qualify as a corrective disclosure . . . It is, after all, impossible to say that an SEC investigation was the moment when the "relevant truth beg[an] to leak out" if the truth never actually leaked out. . . . . It may be possible, in a different case, for the disclosure of an SEC investigation to qualify as a partial

> corrective disclosure for purposes of opening the class period when the investigation is coupled with a later finding of fraud or wrongdoing.

Id. at 1201 n.13.

In Loos v. Immersion Corp., 762 F.3d 880, 890 (9th Cir. 2014), the Ninth Circuit "agree[d] with the Eleventh Circuit's reasoning" in Meyers, writing:

> The announcement of an investigation does not "reveal" fraudulent practices to the market. Indeed, at the moment an investigation is announced, the market cannot possibly know what the investigation will ultimately reveal. While the disclosure of an investigation is certainly an ominous event, it simply puts investors on notice of a potential future disclosure of fraudulent conduct. Consequently, any decline in a corporation's share price following the announcement of an investigation can only be attributed to market speculation about whether fraud has occurred. This type of speculation cannot form the basis of a viable loss causation theory. Accordingly, we hold that the announcement of an investigation, without more, is insufficient to establish loss causation.

Id. And like the Eleventh Circuit, the Ninth Circuit, did "not mean to suggest the announcement of an investigation can never form the basis of a loss causation theory" where the "announcement contains and express disclosure of actual wrongdoing." Id. at 890 n.13.

To be sure, Loos and Meyers dealt with investigations. But notice of an investigation no more reveals fraud than a complaint does, and while both

may be "ominous events," neither shows that a company's previous statements were false or fraudulent.

Plaintiff links investor losses solely to the filing of the Tenet complaint, not a series of partial disclosures of which that complaint was a part. But the market reaction to that filing was just as likely (if not more likely) due to the proposed takeover being thwarted. Whether either of those scenarios or something else caused the price drop is not a question that can be resolved on the pleadings. See In re Harman Int'l Indus., Inc. Sec. Litig., 791 F.3d 90, 111 (D.C. Cir. 2015) ("plaintiffs need not demonstrate on a motion to dismiss that the corrective disclosure was the only possible cause for decline in the stock price"); Lo. Mun. Police Emp. Ret. Sys. v. KPMG LLP, 822 F. Supp. 2d 711, 725 (N.D. Ohio 2011) (stating in the context of a motion to dismiss that "[w]hat ultimately caused Plaintiff's loss is not ripe for the Court to decide"). The fact remains, however, that the Tenet complaint revealed no truths, only allegations, and "the market cannot respond to fraud until it has been revealed." In re Almost Family, 2012 WL 443461 at *2.

B. Allegations Regarding Public Statements After the Filing of the Tenet Complaint

Plaintiff alleges that, after the filing of the Tenet complaint, CHS (1) continued to mislead investors about the merits of the Tenet complaint, and (2) misrepresented the true impact discontinuing the Blue Book would have on CHS's financial performance. This resulted in loss Plaintiff alleges because, on October 26, 2011, CHS released its 3Q2011 results, indicating the rate of admissions fell

by 7%, and, the day following that corrective disclosure, CHS's stock price dropped by 12%.

As with the pre-Tenet complaint allegations, Defendants argue that Plaintiff fails to state a claim for the post-Tenet statements because the First Amended Complaint (1) does not plead any actionable misstatements; (2) fails to plead a strong inference of scienter; and (3) fails to plead the decline in stock price was caused by any alleged misstatement. Defendants also argue that the post-Tenet claim is time-barred. The Court agrees with the last argument.

A "private cause of action that involves a claim of fraud, deceit, manipulation or contrivance in contravention of a regulatory requirement of the securities laws . . . may be brought not later than the earlier of – (1) 2 years after the discovery of facts constituting the violation; or (2) five years after such violation." 28 U.S.C. § 1658(b)(1). "[T]he limitations period in § 1658(b)(1) begins to run once the plaintiff did discover or a reasonably diligent plaintiff would have 'discover[ed] the facts constituting the violation' whichever comes first." Merck & Co. v. Reynolds, 559 U.S. 633, 653 (2010).

Defendants contend that, "[a]t the very least, Plaintiff was on notice of the alleged new claim concerning an October 2011 corrective disclosure when Plaintiff filed its Initial Consolidated Class Action Complaint on July 13, 2012," (Docket No. 178 at 33), but waited until the filing of the First Amended Complaint on October 15, 2015 to raise the claim. Plaintiff does not argue otherwise, but contends that the claim for the post-Tenet

statements relate back to the filing of the initial Complaint on May 9, 2011, making it timely.

"Rule 15(c) of the Federal Rules of Civil Procedure governs when an amended pleading 'relates back' to the date of a timely filed original pleading and is thus itself timely even though it was filed outside an applicable statute of limitations." Krupski v. Costa Crociere S. p. A., 560 U.S. 538, 541 (2010). Pertinent to this case, "[a]n amendment to a pleading relates back to the date of the original pleading when . . . the amendment asserts a claim or defense that arose out of the conduct, transaction, or occurrence set out—or attempted to be set out—in the original pleading." Fed. R. Civ. P. 15(c)(1)(B).

In their moving papers, Defendants argue:

> In deciding whether to permit amendment, a court also should consider "undue delay in filing, lack of notice to the opposing party, bad faith by the moving party, repeated failure to cure deficiencies by previous amendments, undue prejudice to the opposing party, and futility of amendment." . . . Those factors also disfavor treating the Amended Complaint as relating back to the prior Complaint. . . . [T]he new allegations in the Amended Complaint are futile because they fail to state a claim of securities fraud. In addition, Plaintiff's course of conduct is the very picture of "undue delay." Plaintiff's motive for this tardy addition is no secret: Plaintiff sought leave to amend their complaint two days after Defendants brought to the Court's attention just how baseless their prior (April 11, 2011) theory of loss causation was. . . . Plaintiff slept on its proposed new claims for

> three years—until well after the lapse of the statute of limitations. It should not be permitted to add new claims at this late date.

(Docket No. 178 at 34, internal citations and footnote omitted). In response, Plaintiff asserts that "Defendants cannot establish prejudice" and "Plaintiff has not engaged in delay in asserting its claims." (Docket 185 at 33).

In the context of Rule 15(c)(1), these arguments miss the mark.[6] In Krupski, the Supreme Court made clear that "[t]he Rule plainly sets forth an exclusive list of requirements for relation back, and the amending party's diligence is not among them. Moreover, the Rule mandates relation back once the Rule's requirements are satisfied; it does not leave the decision whether to grant relation back to the district court's equitable discretion." Krupski, 560 U.S. at 552-53.

Still, relation back is only appropriate if an amended complaint asserts a claim arising out of the same conduct, transaction, or occurrence that was already pleaded or attempted to be plead. "In

---

[6] Given a bit of a wrinkle in the procedural posture of this case, the making of such arguments is understandable. During a status conference in which the filing of a proposed amended complaint was discussed, Defendants indicated that they might have an objection to such a filing, particularly since they had already filed a Motion to Dismiss. The Magistrate Judge stated, however, that, after consultation with the Judge previously assigned to this case, the matter would be short-circuited so that the Court would not have to address issues twice. That is, he would grant leave to file an Amended Complaint after which Defendants could make any arguments they wished in a renewed Motion to Dismiss.

determining whether the new claims arise from the same 'conduct transaction or occurrence,'" a court's "analysis is guided by 'whether the party asserting the statute of limitations defense had been placed on notice that he could be called to answer for the allegations in the amended pleading.'" Durand v. Hanover Ins. Grp., Inc., 806 F.3d 367, 375 (6th Cir. 2015) (quoting United States *ex rel.* Bledsoe v. Cmty Health Sys., Inc., 501 F.3d 493, 516 (6th Cir. 2007)). "This standard is usually met 'if there is an identity between the amendment and the original complaint with regard to the general wrong suffered and with regard to the general conduct causing such wrong.'" Id. (quoting Miller v. Am. Heavy Lift Shipping, 231 F.3d 242, 250 (6th Cir.2000)).

"Though not expressly stated, it is well-established that the touchstone for relation back is fair notice, because Rule 15(c) is premised on the theory that 'a party who has been notified of litigation concerning a particular occurrence has been given all the notice that statutes of limitations were intended to provide.'" Glover v. F.D.I.C., 698 F.3d 139, 145-46 (3rd Cir. 2012) (quoting Baldwin Cty. Welcome Ctr. v. Brown, 466 U.S. 147, 149 n. 3 (1984)). Thus,

> only where the opposing party is given 'fair notice of the general fact situation and the legal theory upon which the amending party proceeds' will relation back be allowed. . . . Conversely, amendments 'that significantly alter the nature of a proceeding by injecting new and unanticipated claims are treated far more cautiously.'

Id. (internal citation omitted) (quoting, United States v. Hicks, 283 F.3d 380, 388 (D.C. Cir. 2002)).

Here, the 3Q2011 report was not mentioned in the original complaint for the obvious reason that it had yet to issue. However, some nine months after the issuance of that quarterly report, Plaintiff filed its Consolidated Class Action Complaint. While that Complaint alleged material misstatements were made by CHS in each of its released financial results from the Second Quarter of 2006 to the Fourth Quarter of 2010, no mention is made of the Third Quarter of 2011. Moreover, the class period is defined to include purchasers of stock from July 27, 2006 through April 8, 2011, with the close date corresponding to the filing of the Tenet complaint. Indeed, the Consolidated Class Action Complaint alleged that "[t]his class action was precipitated by disclosures made in April 2011 by Tenet" that caused "CHS stock [to] immediately plummet[] by nearly 36% in one day." (Docket No. 68, Consolidated Complaint ¶ 3).

"[T]he purpose of relation back [is] to balance the interests of the defendant protected by the statute of limitations with the preference expressed in the Federal Rules of Civil Procedure in general, and Rule 15 in particular, for resolving disputes on their merits." Krupski, 560 U.S. at 550. That purpose would be thwarted, the Court believes, by allowing relation back under the particular circumstances of this case.

Allegations of post-Tenet conduct constitutes an entirely new securities fraud claim. It alleges a different fraud and alleged corrective disclosure that expands the size of the putative class, extends the

class period, and (by Defendants' calculations) adds hundreds of millions of dollars in potential damages. The initial Consolidated Class Action Complaint hardly gave Defendants notice of the potential scope of Plaintiff's expanded claim, although it certainly could have and should have. Instead Plaintiff waited another three years to assert a claim based on post-Tenet statements. While diligence is not a factor in the 15(c)(1)(B) analysis, surprise is. Bledsoe, 501 F.3d at 516 (quoting Santamarina v. Sears, Roebuck & Co., 466 F.3d 570, 573 (7th Cir. 2006)). ("'The criterion of relation back is whether the original complaint gave the defendant enough notice of the nature and scope of the plaintiff's claim that he shouldn't have been surprised by the amplification of the allegations of the original complaint in the amended one'"); Marshall v. H & R Block Tax Servs., Inc., 564 F.3d 826, 829 (7th Cir. 2009) ("And if we are right that the liability asserted in the original claim was significantly less extensive than the liability now claimed . . ., there is no relation back; from the standpoint of the original claim, the expansion of potential liability was a surprise.").

IV. Conclusion

On the basis of the foregoing, Defendants' Motion to Dismiss the Amended Complaint will be granted. An appropriate Order will enter.

/s/ Kevin H. Sharp
KEVIN H. SHARP
UNITED STATES DISTRICT JUDGE

APPENDIX C

FILED
Jan 18, 2018
DEBORAH S. HUNT, Clerk

No. 16-6059

UNITED STATES COURT OF APPEALS
FOR THE SIXTH CIRCUIT

NORFOLK COUNTY RETIREMENT SYSTEM, ET AL.,	)	
Plaintiffs,	)	
NEW YORK CITY EMPLOYEES' RETIREMENT SYSTEM; TEACHERS' RETIREMENT SYSTEM OF THE CITY OF NEW YORK, ET AL.,	)	ORDER
Plaintiffs-Appellants,	)	
v.	)	
COMMUNITY HEALTH SYSTEMS, INC.; WAYNE T. SMITH; W. LARRY CASH,	)	
Defendants-Appellees.	)	

BEFORE: COLE, Chief Judge; SUTTON and KETHLEDGE, Circuit Judges.

The court received a petition for rehearing en banc. The original panel has reviewed the petition for rehearing and concludes that the issues raised in the petition were fully considered upon the original submission and decision of the case. The petition then was circulated to the full court. No judge has requested a vote on the suggestion for rehearing en banc.

Therefore, the petition is denied.

ENTERED BY ORDER OF THE COURT

/s/ Deborah S. Hunt
Deborah S. Hunt, Clerk

APPENDIX D

15 U.S.C. § 78j provides in relevant part:

§ 78j. Manipulative and deceptive devices

It shall be unlawful for any person, directly or indirectly, by the use of any means or instrumentality of interstate commerce or of the mails, or of any facility of any national securities exchange--

* * *

(b) To use or employ, in connection with the purchase or sale of any security registered on a national securities exchange or any security not so registered, or any securities-based swap agreement any manipulative or deceptive device or contrivance in contravention of such rules and regulations as the Commission may prescribe as necessary or appropriate in the public interest or for the protection of investors.

APPENDIX E

15 U.S.C. § 78u-4 provides in relevant part:

§ 78u-4. Private securities litigation

* * *

(b) Requirements for securities fraud actions

* * *

(4) Loss causation

In any private action arising under this chapter, the plaintiff shall have the burden of proving that the act or omission of the defendant alleged to violate this chapter caused the loss for which the plaintiff seeks to recover damages.

APPENDIX F

17 C.F.R. § 240.10b-5

§ 240.10b-5 Employment of manipulative and deceptive devices.

It shall be unlawful for any person, directly or indirectly, by the use of any means or instrumentality of interstate commerce, or of the mails or of any facility of any national securities exchange,

(a) To employ any device, scheme, or artifice to defraud,

(b) To make any untrue statement of a material fact or to omit to state a material fact necessary in order to make the statements made, in the light of the circumstances under which they were made, not misleading, or

(c) To engage in any act, practice, or course of business which operates or would operate as a fraud or deceit upon any person,

in connection with the purchase or sale of any security.

APPENDIX G

Rule 15 of the Federal Rules of Civil Procedure

Rule 15. Amended and Supplemental Pleadings

(a) Amendments Before Trial.

(1) *Amending as a Matter of Course*. A party may amend its pleading once as a matter of course within:

(A) 21 days after serving it, or

(B) if the pleading is one to which a responsive pleading is required, 21 days after service of a responsive pleading or 21 days after service of a motion under Rule 12(b), (e), or (f), whichever is earlier.

(2) *Other Amendments*. In all other cases, a party may amend its pleading only with the opposing party's written consent or the court's leave. The court should freely give leave when justice so requires.

(3) *Time to Respond*. Unless the court orders otherwise, any required response to an amended pleading must be made within the time remaining to respond to the original pleading or within 14 days after service of the amended pleading, whichever is later.

(b) Amendments During and After Trial.

(1) *Based on an Objection at Trial*. If, at trial, a party objects that evidence is not within the issues

raised in the pleadings, the court may permit the pleadings to be amended. The court should freely permit an amendment when doing so will aid in presenting the merits and the objecting party fails to satisfy the court that the evidence would prejudice that party's action or defense on the merits. The court may grant a continuance to enable the objecting party to meet the evidence.

(2) *For Issues Tried by Consent*. When an issue not raised by the pleadings is tried by the parties' express or implied consent, it must be treated in all respects as if raised in the pleadings. A party may move--at any time, even after judgment--to amend the pleadings to conform them to the evidence and to raise an unpleaded issue. But failure to amend does not affect the result of the trial of that issue.

(c) Relation Back of Amendments.

(1) *When an Amendment Relates Back*. An amendment to a pleading relates back to the date of the original pleading when:

(A) the law that provides the applicable statute of limitations allows relation back;

(B) the amendment asserts a claim or defense that arose out of the conduct, transaction, or occurrence set out--or attempted to be set out--in the original pleading; or

(C) the amendment changes the party or the naming of the party against whom a claim is asserted, if Rule 15(c)(1)(B) is satisfied and if, within the period provided by Rule 4(m) for serving the summons and complaint, the party to be brought in by amendment:

(i) received such notice of the action that it will not be prejudiced in defending on the merits; and

(ii) knew or should have known that the action would have been brought against it, but for a mistake concerning the proper party's identity.

(2) Notice to the United States. When the United States or a United States officer or agency is added as a defendant by amendment, the notice requirements of Rule 15(c)(1)(C)(i) and (ii) are satisfied if, during the stated period, process was delivered or mailed to the United States attorney or the United States attorney's designee, to the Attorney General of the United States, or to the officer or agency.

(d) Supplemental Pleadings. On motion and reasonable notice, the court may, on just terms, permit a party to serve a supplemental pleading setting out any transaction, occurrence, or event that happened after the date of the pleading to be supplemented. The court may permit supplementation even though the original pleading is defective in stating a claim or defense. The court may order that the opposing party plead to the supplemental pleading within a specified time.

APPENDIX H

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UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF INDIANA
FORT WAYNE DIVISION

UNITED STATES *ex rel.*, and NANCY REUILLE,	)	
Relator,	)	
vs.	)	CASE NO.: 1:09-CV-007
COMMUNITY HEALTH SYSTEMS PROFESSIONAL SERVICES, CORPORATION, and LUTHERAN MUSCULOSSKELETAL CENTER, LLC, d/b/a LUTHERAN HOSPITAL,	)	
Defendants.	)	

COMPLAINT AND JURY DEMAND

COME NOW, Relator, Nancy Reuille, by counsel, Loren K. Allison, and files this instant cause of action on behalf of the United States of America against Community Health Systems Professional

Services, Corp. ("CHS") and Lutheran Musculosskeletal Center, LLC d/b/a Lutheran Hospital ("Lutheran") for a violation of the Federal False Claims Act.

BACKGROUND

1. Nancy Reuille, Relator, is a female resident of Zanesville, Indiana, who worked for Lutheran from 1985 to October 1, 2008. Her last position with Lutheran was Supervisor of Case Management.

2. Defendant, CHS, is a corporation doing business in the State of Indiana and in Fort Wayne, Allen County, Indiana, as Lutheran Health Network, d/b/a Lutheran Hospital, St. Joseph Hospital, Bluffton Regional Medical Center, Dukes Memorial Hospital, Dupont Hospital, Kosciusko Community Hospital, Redimed & Rehabilitation Hospital of Fort Wayne. CHS supervises the activities of such agents and instrumentalities throughout the United States.

3. The False Claims Act, originally enacted in 1863 during the Civil War, was substantially amended by the False Claims Amendments Act of 1986 and signed into law on October 17, 1986. Congress enacted these amendments to enhance the Government's ability to recover losses sustained as a result of fraud against the United States and to provide a private cause of action for the protection of employees who act in furtherance of the purposes of the Act. Congress acted after finding that fraud in federal programs and procurement is pervasive and that the False Claims Act, which Congress characterized as procurement is pervasive and that the False Claims Act, which Congress characterized as the primary tool for combating fraud in

government contracting, was in need of modernization.

4. The Act provides that any person who knowingly submits a false or fraudulent claim to the Government for payment or approval is liable for a civil penalty of up to $10,000.00 for each such claim, plus three times the amount of the damages sustained by the Government, and attorneys' fees. The Act allows any person having information regarding a false or fraudulent claim against the Government to bring a private cause of action for himself and on behalf of the Government and to share in any recovery. The complaint is to be filed under seal for 60 days (without service on the defendant during such 60 day period) to enable the Government (a) to conduct its own investigation without the defendants' knowledge and (b) to determine whether to join the action. The Act further provides that any employee who is subjected to retaliation by an employer for lawful actions taken in furtherance of an action under the Act is entitled to all relief necessary to make the employee whole, including but not limited to reinstatement with full seniority, two times the amount of back pay, interest on back pay, special damages, costs and reasonable attorneys' fees.

5. This dispute arises under the Federal Medicare program administered by the Centers for Medicare and Medicaid Services (CMS), formerly the Health Care Financing Administration (HCFA). The Medicare program was established to provide health insurance to the aged and disabled. 42 U.S.C. § 1395(c). CMS is the agency of the Department of Health and Human Services responsible for

administering the Medicare program. CMS's payment and audit functions under the Medicare program are contracted out to insurance companies known as fiscal intermediaries. Fiscal intermediaries determine payment amounts due the providers under medicare law, regulations and interpretive guidelines published by CMS. *See*: 42 U.S.C. § 1395(h), C.F.R. 413.20-413.24.

6. Based on these provisions, Reuille seeks to recover damages and civil penalties arising from defendant's presentation of false claims to the United States Government.

FACTS

7. Relator was an employee of Lutheran Hospital of Indiana for twenty-three (23) years, from 1985 until October 1, 2008, as a registered nurse with a B.S.N. in Nursing. In 1997, she entered management as the MDS Coordinator for a newly formed Transitional Care Unit which required an extensive knowledge of Medicare rules and regulations for nursing homes. This unit was closed in 2000 due to financial considerations. Ms. Reuille applied for and accepted the supervisory position of Supervisor of Case Management in January of 2000. In this position she was responsible for supervising ten (10) Case Managers which reviewed all of the Medicare, Medicaid, private insurance, and self-pay medical records of hospitalized patients on a daily basis. The Relator was familiar with Medicare "medical necessity" criteria for hospitals and she designed and implemented review forms and auditing tools used by the Case Management Department.

8. Reuille was recruited by the hospital's billing office to be the Case Management, nursing and medical denial specialist who worked to reverse denials of coverage related to clinical/medical criteria and billing problems. In this position, she issued medical appeals based on medical record audits and clarification of information with the Lutheran Billing Department. The Relator also worked closely with the Lutheran Registration Department in the process of rectifying errors on denied accounts caused by incorrect account admission data. She directly contacted the insurance companies, Medicare and Medicaid concerning issues of medical appropriateness and/or payment and developed a unique skill set. Familiar with all aspects of patient account auditing, Reuille was able to follow a patient's claim from admission to discharge, noting the correctness of the "patient-type" whether Inpatient, Outpatient, or 23 hour Observation, verifying medical necessity appropriateness, verifying that the bill correctly matched the physician's written patient-type order (Inpatient, Outpatient or 23 Hour Observation) and was able to check the bills to verify that charges matched actual services received *i.e.* correctly registered, correctly followed physician orders, met "medical necessity", and billed as ordered.

9. As Supervisor of Case Management, Reuille was responsible for several audits of financial gravity. Among the audits was the Medicare "One-Day Stay" audit, a "23 Hour observation" length of stay audit, and an "Impatient Only" procedure audit. In her job capacity, Reuille assisted Lutheran Hospital to monitor the medical necessity and accurate processing of patient accounts. Under her

supervision, the Case Managers reviewed the hospital's current and retrospective patient charts daily to ensure that the care prescribed, the demographic and clinical record information, and the billing information met the level of care and authorization guidelines for authorization and payment as set by private insurances, Medicare, and Medicaid.

Over the years, Reuille developed a comprehensive knowledge of all aspects of patient case management. From the years of 2000 to 2008, given her expertise, Reuille along in conjunction with her immediate supervisor, Division Director Ted Weimerskirch attempted to compel hospital divisions to smoothly process accounts and to work together to correct processes that were working ineffectively and therefore, causing multiple processing errors. Reuille noted and her supervisor acknowledged that Lutheran Hospital had no coordination of process and/or cooperation between Administration, Compliance, the Registration Department, the Clinical Review/Case Management Department, and the Billing Department. Any attempts to coordinate and improve the process resulted in each individual area responding with a general "that's not my area-not my responsibility".

10. As a consequence, on March 24, 2000, Health Care Excel, on behalf of the Indiana Medicaid program, completed an on-site audit at Lutheran Hospital based on a review of 1997 accounts related to the "medical necessity" of claims which compared Lutheran's billing and practice patterns to the billing and practice patterns for the providers in the same geographic area and specialty. Deficiencies leading to

overpayment and mis-utilization were identified on multiple accounts and a recoupment of $177,000.00 was requested under Indiana Health Coverage Program criteria (405 IAC 1-1-5). In a majority of the recouped accounts the inappropriate level of care and inpatient admission rather then observation status were the reasons for overpayment of the accounts. "Problems" noted, *included incorrect admit date and discharge dates that were billed, incorrect discharge codes, multiple treatment rooms were billed for the same date of service, inappropriate short inpatient stays and failure to meet inpatient medical necessity of short stays versus billing as 23 Hour observation status.*

Reuille contends that these same "errors" have occurred routinely during her years of employment in the Case Management Department. Any attempts to initiate corrective action have been met with resistance since no individual area has been directed to accept responsibility. The process at Lutheran Hospital is purposely "ineffective" and the result has been discrepancies that stem from the medical records purposely not substantiating the billed charges. Reuille contends that "mis-utilization" and overbilling have cost Medicare, Medicaid, and private insurance companies millions of dollars in overpayment due to the many deficiencies in Lutheran Hospital's purposely deficient system.

As a consequence, Reuille cites two issues that clearly demonstrate a pattern of intentional abuse of the Medicare system. The two issues for which Reuille seeks relief are:

a. False "23 hour observation" billing after outpatient surgeries and procedures;

notably excessive hours of observation care being reported which do not correlate with actual dates and times of service.

b. Intentional assignment of "inpatient" status to "One-Day Stays" accounts to allow Lutheran to fraudulently receive "inpatient" reimbursement on cases that clearly do not meet "inpatient" intensity of service or severity of illness, per established Medicare criteria.

A. Inaccurate "23 Hour Observation" billing after outpatient surgeries and procedures.

11. *Lutheran Hospital is assigning excessive hours of observation care, and billing for time when the patient is not in the facility. The dates and times of service do not correlate with actual dates and times of the actual observation services.*

12. While involved with precertification work at Lutheran which required daily monitoring of patient charts (medical records), Reuille noticed recurring claim issues regarding inaccurate processing and falsification of Medicare "23 Hours Observation" accounts. Reuille has first hand knowledge that Lutheran Hospital is falsifying the dates and times of "23 Hour Observation" services which were supplied to patients who underwent "Outpatient" surgeries and procedures. These were accounts in which patients stayed past normal recovery time as "23 hour observation" to receive additional monitoring, rather then going directly home after surgery. Incorrect quantities of "observation" hours are being reported on a UB92 (Medicare bill).

13. By definition "23 HOUR OBSERVATION SERVICES" are those outpatient services furnished by a hospital on the hospital premises, including use of a bed and periodic monitoring by a hospital's nursing or other staff, which are reasonable and necessary to evaluate an outpatient's condition or determine the need for possible admission of the hospital as an "inpatient" (Medicare Claims Processing Manual, Pub. 100-4, Chapt. 4, sections 290-290.6). According to Medicare studies, their need for "observation" services after outpatient procedures and surgeries is that they can usually be expected to discharge from the facility immediately after the normal recovery period not requiring "observation" saving the federal government money. However, if there is a medical complication which the physician documents, the patient who needs further monitoring to determine if they are ready for discharge or if they require "inpatient" hospitalization can be placed into "23 hour observation" status. This status is less costly to the medicare system since an "inpatient" room and board charge is not assigned to an "observation" claim. Rather, the postoperative "observation" services have been "bundled or packaged" with the costs of the outpatient surgery and recovery room charges into a procedural ambulatory payment classification (APC) since April 2002. Medicare utilizes a set of "medical necessity" criteria entitled InterQual to determine whether "observation" or "inpatient" status is appropriate. This requires the physician to monitor and document the patient's medical condition in the recovery room and after an adequate recovery time, to determine the patient's clinical needs and decide whether to discharge the patient or admit them as

an "inpatient". If the physician needs further time after normal recovery to determine this clinical path, they can use "23 hour observation" status to do so as long as the patient's medical condition dictates the care. To do this, he writes and dates an order for "23 hour observation". This timed and dated order indicates the beginning of "23 hour observation" billing and can never be determined prior to the surgery and recovery period. "23 hour observation" charges are calculated and reported by the hour from the time the physician writes the "observation" order after recovery until the time the physician discharges the patient or converts their status to "inpatient" because of their medical condition.

14. The express purpose of "23 hour observation" monitoring is a "decision time" in which the patient with a postoperative complication, after normal 4-6 hour recovery, is monitored and treated with nursing care. This time gives the physician a period in which to decide if the patient will be medically stable to discharge after "observation" or whether the patient's condition medically indicates a need for further treatment as an "inpatient".

15. Reuille noted that the admission time to the Lutheran hospital for many surgical services per the patient's "facesheet" (initial page of their chart) on their medical record did not follow the "normal and customary" surgical procedure admission and recovery times. Facesheets indicated that patients were being admitted between midnight and 5:00 o'clock a.m. into 23 hour observation status. Physicians as a practice, however, do not bring a patient into the hospital for a "scheduled" outpatient surgery in the middle of the night. Patients

normally appear for surgery between 5:00 o'clock a.m. and midafternoon. Reuille began to suspect negligence, at a minimum, in the processing of accounts. She suspected "observation" was being reported before surgery and recovery and before admission to the hospital. She began to audit these accounts per her supervisor's express instruction. The auditing criteria she used was a) "23 hour observation" status per the physicians order and established Medicare criteria and b) admission times between midnight and 11:00 o'clock a.m. Reuille initially tried to correct these cases individually as they were found, believing they were "flukes" in the system. However, these cases continued and increased in frequency so she gathered some example cases. Reuille more closely audited these medical records containing these unusual times to determine c) the actual time the patient arrived for surgery, d) the time they went to the recovery room after surgery, e) the time the physician wrote the "23 hour observation" order, f) the time the patient arrived on the nursing unit from the Recovery Room, and g) she reviewed the patient's bill noting the quantity of observation minutes/hours being charged on these accounts.

16. "23 hour observation" claims are calculated for reporting on the UB92 by the minute the patient is in a bed under "23 hour observation status based on the time the physician writes the "23 hour observation" order on the chart in the Recovery Room, postoperatively, having made a decision after a normal recovery period that the patient is not ready or safe to go home medically. It is based on a documented medical complication altering the usual course of outpatient surgical progress; *i.e.* discharge.

On the other hand, "inpatient" accounts are billed a single daily bed charge based on whether the bed assignment is to a medical or intensive care bed, etc. and the patient is charged a set amount per day regardless of the number of hours the patient is in the bed from midnight to midnight. Prior to 2002, Medicare allowed a separate payment for each hour of observation care a patient received. In 2002 the rules changed and "observation" services were paid as a "packaged" APC (ambulatory payment classification) procedure amount for post-surgical observation but there continues to be payment for observation built into the "package" with surgery, recovery room and other miscellaneous charges. "23 hour observation" charges are required to be reported accurately on the UB92 (Medicare bill) even though reimbursement is packaged. Per Reuille's communication with a Health Insurance Specialist and counsel for CMS.

17. Reuille began checking the bills and found that the number of minutes being reported on these accounts was not calculated from the time the surgeon wrote the "23 hour observation" order after recovery. *Not only was this time not "postoperative and after recovery" but it was often a time in the middle of the night when the patient was not even physically in the hospital. This false reporting violates Medicare guidelines and results in excessive billing and fraudulent reporting. The implication of billing for erroneous times and time the patient was not in the facility results in claims reporting an estimated 3-10 excess "observation" hours per claim. This practice has been documented for three (3) years. (All payors are receiving these inaccurate claims,*

including Medicaid, Medicare and private insurance companies).

Reuille took examples of these accounts to administrator Karen Springer, Chief Operating Officer (C.O.O.). *The response Reuille received from Springer indicated that she was aware of the problem but placed the blame for false claims upon the surgeons failing to follow the Medicare guidelines for writing the "23 hour observation" orders after recovery, which was, again, Lutheran's obligation to manage.* Reuille, after meeting with intransigence from Springer voiced her disagreement. She believed the physicians were correctly ordering the start of observation but the hospital was reporting no record. She reviewed these accounts again verifying with Springer that the problem was not the physician's orders for they were indeed written at a time after surgery, not <u>prior</u> to surgery. After relating as much to Springer again, Reuille continued to monitor accounts with these odd times to see if any correction of this error was implemented. No correction occurred, resulting in false claims being submitted with the COO's express knowledge. Months later, in the course of attempting to correct one of these individual accounts, Reuille met with Ms. Julie Nankervis, the Supervisor of the Registration Department. Correction of patient admission registration information is managed through the Lutheran Hospital Registration Department as well as through the Billing department if a patient has already been discharged from the hospital. *Nankervis acknowledged the problem but did not indicate any intention of follow-up on the issue and none was undertaken since the "errors" continued.* Reuille continued to audit for these false records and

these inaccurate dates and times were still occurring as of the date of Reuille's constructive discharge from employment on October 1, 2008.

The financial impact of over reporting "23 hour observation" time varies according to the payor responsible for reimbursement. For private insurances there is a great impact since they continue to encourage the use of "23 hour observation" as does Medicaid. Private insurances reimburse these services according to the method dictated in the contracts negotiated with Lutheran Hospital and "observation" rules are gauged by Medicare's guidelines. The impact on payment by Medicare and Medicaid is more difficult to determine. These cases audited are "short stays" meeting the "observation" criteria per the Department of Health and Human Services (DHHS) Centers for Medicare and Medicaid Services (CMS, Pub. 100-2 Medicare Benefit Policy). The 2002 rule has packaged "observation" services with the surgical procedure and recovery and additional "observation" time packaged into the surgical APC would increase the packaged cost, resulting in an overpayment to Lutheran and to Medicare's detriment.

18. Reuille contends that it is fraudulent to misrepresent the date/times of "observation" services especially since thousands of accounts with post-surgical and post-procedure "23 hour observation" were and continue to be falsely reported.

B. Medicare "One Day Stays"

19. In 2001, as Supervisor of Case Management and under the direct supervision of Division Director Weimerskirch, Reuille began a proactive Medicare audit at Lutheran Hospital of Medicare "One-Day Stays". The focus of the audit was accounts in which the patient had a written order by the physician to be an "inpatient" but the length of the hospital stay was less than one day. These hospital visits were being processed by Lutheran as "inpatient" rather than the more "medically necessary" and less costly patient-admission type, "23 hours observation". The audit was initiated in response to information received by Weimerskirch indicating that the Office of the Inspector General (OIG) was investigating "One-Day Stays". The OIG suspected Medicare overpayment. Their records indicated that 10% of all Medicare patients were improperly admitted and discharged on the same day and were admitted as "inpatients". The OIG suspected nationwide Medicare overpayment of billions of dollars related to these hospitalizations failing to meet "inpatient" medical criteria. Since "23 hour observation" was a valid outpatient status for one day stays, OIG questioned if "observation' was not a more appropriate billing status based on medical criteria. The very fact that the patient was able to discharge on the same day would indicate a lesser intensity of service required than "inpatient" services. Weimerskirch believed that OIG/Medicare audits would soon follow the report. Therefore, Weimerskirch, with the approval of Steve Carroll, Chief Financial Officer (C.F.O.) initiated an audit to correct any such errors at Lutheran. Reuille was asked to be the R.N. Case Management Auditor for

Medicare "One-Day Stays" and her results were reported to Weimerskirch on a monthly basis. Cases not meeting "inpatient" criteria were forwarded to Carroll for authorization to "write-off" account charges since Medicare rules prohibited billing care that did not met Medicare necessity as "inpatient" or converting the claims back to "23 hour observation" status after discharge from the facility. Lutheran was aware that, billing for medically unnecessary services was fraudulent.

20. Health Care Excel followed-up with an HPNP (Hospital Payment Monitoring Program) audit completed by Medicare QIO staff of "One-Day Stays" in August of 2006. They requested 22 charts dated August 1, 2005 - October 31, 2005 to establish a baseline. The goal of HPNP was to reduce unnecessary "inpatient" admissions for "One-Day Stays" related to incorrect coding, non-covered, insufficiently documented, or "medically unnecessary". Sixteen of the twenty-two charts failed abstraction resulting in a 73% error rate of inappropriate inpatient admissions of "One-Day Stays". A further audit of 10 charts dated December, 2005 to January, 2006 failed abstraction with a continuing error rate of 54% of inappropriate admissions. The major finding of this audit was that most stays failing the audit did not meet the medical criteria for "inpatient" status and would have been more appropriate as "23 hour observation", and hence "cheaper".

21. Reuille began her audit by generating a list of Medicare recipient records that met certain audit criteria, *i.e.* patients that 1) were admitted and discharged within one day; 2) the patient admission

type was "inpatient"; and 3) patients who expired were eliminated from the audit. As a nurse auditor, Reuille then reviewed these records per InterQual Medical Criteria, (the established standard) used by Medicare to determine if the services ordered as "inpatient" by the physician and provided by Lutheran for 24 hours of less, met inpatient "medical necessity" criteria. The audit revealed a significant percentage of account did not meet "inpatient" criteria. For example in the last quarter of 2001, this audit at Lutheran Hospital indicated that 19% of the Medicare admissions fell into the "one-day stay" category. Of this percentage, 13% of these stays did not meet medical criteria for "inpatient" billing but should have been ordered by the physician as "23 hour observation". Since Health Care Excel (Medicare) only allows for a 5% error rate, this audit revealed an existent problem at Lutheran. Reuille and Weimerskirch began working with physicians by phone, per meetings, and per written communication to attempt to encourage compliance with Medicare's guidelines for short stays. They educated the physicians that they could use "23 hour observation" or "outpatient" status when "inpatient" medical criteria were not present. The dollar amounts written off by the hospital during these auditing years (by Reuille) varied but averaged $50,000.00 per month.

22. As a consequence, of her efforts, Reuille was removed from this auditing position in September of 2006, a move directly related to the significant financial implication of these write-offs to the hospital's profit. The new Supervisor of Case Management, Rebecca Miller, assumed these audits until October 2007 upon Ms. Miller's resignation,

Sue Heckley, R.N. took over the audits and completed them monthly until CHS (Community Health Systems) purchased and took over Lutheran Hospital in December 2007.

23. CHS abruptly discontinued the proactive Medicare "One-Day Stay" audits altogether stating that it was not part of their protocol. CHS does not encourage 23 Hour Observation status regardless of the length of stay. Per Bill McCray, head of parent company CHS Case Management, "inpatient" status is justified by the CHS criteria set, which conflicts with CMS guidelines. Immediately prior to the takeover by CHS, Case Manager Beckley was identifying many inappropriate "inpatient" short stays and the write-offs varied from $50,000.00 to $170,000.00 per month, a monetary loss CHS would not permit.

24. Reuille contends that there has been a dramatic decrease in the volume of "23 Hour Observation" cases and a dramatic increase in the number of "inpatient" "one-day hospitalizations under the new owner, CHS, for Lutheran's benefit. McCray visited Lutheran in January 2008, and met with his new Case Managers. He told them that CHS has an intense focus on case management and that they would all require education on CHS medical criteria contained in the corporation's "Blue Book". Reuille reviewed this book and compared it with InterQual which Medicare uses and which Triad Hospitals, the former hospital owners used. She found the book *exceptionally simplistic* and *nonspecific* and *according to the Blue Book virtually any case could be construed as meeting "inpatient" medical criteria to detriment of the federal government*. By

illustrative example, if anywhere in a chest pain patient's past medical history they had a heart attack or heart disease history it was deemed appropriate per the Blue Book for "inpatient" care simply based on this past history, without significant current symptoms or treatment. According to InterQual criteria, that same patient would be determined to be appropriate for "observation" for a single day to rule out a heart attack and then the physician could determine if further inpatient care or a discharge would be appropriate. Under the Blue Book criteria, CHS would receive payment for a one-day inpatient DRG (Diagnostic Related Group - a payment classification) stay for this case. Considering the large number of Lutheran one-day stays this correlates to excessive overbilling of stays for which there was a less expensive level of care available. This practice continued as of the date of Reuille's constructive discharge.

25. A former case manager and a current director learned in an early 2008 meeting conducted by McCray, that thereafter, Lutheran was to "manage up" diagnostic related groups. Prior to CHS, when a elderly patient was released from Lutheran to facilities such as nursing homes, long term care facilities or hospice, the DRG payment was split between Lutheran and the respective facility receiving the former Lutheran patient. (The portion of the payment is based on the time spent in each respective facility). McCray consequently, mandated to CHS case managers that they "manage up" for (manipulate Medicare rules) these DRG's by retaining the patient at Lutheran for an extra day or more contending that the elderly are perpetually in need of additional hydration or physical therapy -

thus permitting Lutheran to recoup the majority of transfer DRG payment - thus increasing reimbursement to the hospital by delaying the patient's discharge to the waiting facility. This practice violates the "medical necessity" criteria established by Medicare, and demonstrates that CHS is engaging in a concerted effort to, silently or otherwise, file false claims. McCray informed physicians, too, that it is CHS policy to appeal denials by Medicare of "one day stays" as inappropriate "inpatient" hospitalizations rather that to encourage voluntarily assignment of a lower level of care and reimbursement, *i.e.* "23 hour observation".

26. Questioning an increasing trend making all patients "inpatient" was how Reuille learned that CHS was training the Case Management staff in educating the physicians to utilize CHS inpatient status to increase revenue. Reuille concluded that reasonable minds can presume any "blame" for such "errors" is placed on physicians who are independent contractors and not Lutheran employees.

27. Within a month of purchase of CHS, Reuille noted the number of "23 Hour Observation" admissions began to decrease and the cases previously seen as "observation" were being admitted as "inpatient". Reuille, upon being removed as auditor in September, 2006 was retained in the position of Supervisor of Precertification, with a staff of one, still in the Case Management Department, but not as an active "manage" she received a copy of all admission facesheets for the previous day the following morning. Viewing both "inpatient" and "23 Hour Observation" facesheets, Reuille witnessed a

dramatic increase in "inpatient" cases daily as well as dramatic decrease in the number of "observation" facesheets, while total number of daily cases remained approximately the same. Reuille and her staff were responsible for reporting the clinical information to private insurance companies, managed Medicare companies, and managed Medicaid carriers to obtain medical authorization numbers for use in billing these accounts. Starting in February 2008, the workload of handling "inpatient" accounts versus "23 Hour Observation" accounts reversed itself from the pattern of previous years where mostly "observation" status had to be managed by calling to see if precertification was required. "Inpatient" cases almost always required precertification, so Reuille noted a dramatic increase in her area's caseload of "inpatient" precertification of short stays. When Reuille questioned the Case managers about the reason a short stay case that was customarily "observation" was now being presented as "inpatient", she was told by the Case managers, "that is how CHS insists it be done". CHS is openly dictating the use of "inpatient" status for these short, one-day stays.

28. A 2002 Medicare guideline change stopped separate reimbursement for "23 Hour Observation" care except for the diagnoses of chest pain, congestive heart failure, and asthma. Medicare Claims Processing Manual, Pub. 100-4, Chpt. 4, sections 290-290.6. Prior to April 2002, Medicare allowed a separate per hour reimbursement for each hour a patient was in "observation" status starting at the time the physician wrote the "admit to 23 hour observation" order until he wrote the "discharge" order releasing the patient from hospitalization. The

use of "observation" status has not been eliminated, the reimbursement has simply been "bundled" with the remainder of the charges for the stay rather than having a separate "room charge" reimbursement for the hours of "observation" care except for the three diagnoses already cited. A previously acceptable payment for "observation" is now an issue of decreasing revenue for hospitals. As mentioned previously, CHS has responded to this threat to revenue by setting internal guidelines that mandate the use of the more lucrative "inpatient" status, as opposed to Medicare's evaluation standard of "medically necessary".

29. In summary:

    a. Dating back to 2000, internal proactive audits of "One-Day" inpatient stays resulted in thousands of dollars in write-offs for lack of medical necessity for "inpatient" care;

    b. Reuille and Weimerskirch, engaged in physician education in an attempt to help physician's understand that 23 hour observation status was more appropriate for the majority of one-day hospitalizations. The physicians understood and began to order this less costly method of treatment;

    c. In 2002 Medicare changed the payment guidelines for 23 hour observation status. No longer was a separate payment made for the hours in observation status, rather a bundled payment was allowed for total services during the stay which included an amount for observation care. The

frequently used "observation" status became a negative revenue producer;

d. Unwilling to lose the revenue, CHS began changing the case management of short stay cases, educating physicians and Case Managers to use "inpatient" status rather than "23 hour observation" in direct opposition to the training given to physician's in earlier years. CHS justified this by the use of questionable medical criteria they devised and different than that established by Medicare, *i.e.* Blue Book v. InterQual criteria.

30. Reuille resigned from Lutheran Hospital on October 1, 2008 believing knowledge of and participation in, as Medicare and private insurance companies. Having already addressed these issues without positive resolution at Lutheran, Reuille now seeks redress.

C. RETALIATION

31. In early 2006 there was a department reorganization in Case Management and Reuille was removed from the responsibility of direct supervision of the Case Managers. She retained the function of chart auditor under the direct supervision of Weimerskirch, Division Director of Social Services. She also assumed responsibility for the portion of the Case Management Department which was responsible for precertification of all hospitalizations. This required contacting payors, whether private insurance, managed Medicare, managed Medicaid, etc. with clinical information and obtaining authorizations to submit with the patient's claims.

32. In September, 2006 Reuille was removed from the position of "chart auditor" at the directive of Lutheran Administration over and above Weimerskirch. She was given the directive to stop auditing accounts by Mary Ellen Brill, Division Director of Case Management and Quality Improvement, under the authority of Steve Carroll, Chief Financial Officer of Lutheran Hospital. The Relator asserts that her removal from this job was directly related to financial considerations, *i.e.* the writing off of thousands of dollars she identified through her audit of Medicare "One Day Stays" because the audits were identifying many inappropriate inpatient "one day hospitalizations" per InterQual medical criteria.

33. Frustrated and exhausting all internal administrative remedies, Reuille filed a charge with the Equal Employment Opportunity Commission (EEOC) on June 26, 2007, EC-0101-A7-24D-2007-00328, alleging age discrimination and "retaliation". In her charge, she addressed the problems she was enduring in the workplace:

> "I have been satisfactorily performing my job duties for my employer since January of 1985. In September of 2006 my job duties were redefined and the bulk of my responsibilities were given to a younger less experienced employee. During a departmental meeting in November of 2006, this same employee was announced a supervisor over myself and another case management supervisor as part of a restructuring plan for our department. Despite my years of experience in this type of position, I was excluded from consideration for this

> position. Immediately following this meeting I wrote a grievance letter to the Human Resource Department protesting what I believe to be an act of age discrimination on the part of the Division Director of Quality Services. Since that time, I have been excluded from departmental supervisor meetings and my job duties have been reduced to that of a phone nurse with very little supervisory authority. Additionally, the Division Director of Quality Services has stopped communication with me even though she is one of my supervisors. Recently, this position has been vacated and posted on our electronic hospital notice-board and I applied for it. I have not been contacted about this position and immediately after I applied, the posting was taken down."

34. On September 30, 2008, the EEOC issued Reuille a "right to sue" letter and on October 1, 2008, she handed the Division Director of Case Management, Liz Malmstrom her notice of intention to resign due to "intolerable work conditions" and based upon "a good faith belief that Lutheran Hospital of Indiana is knowingly and intentionally engaging in fraud". Per Lutheran Hospital protocol and the employee handbook, she provided the Defendants more than three (3) weeks notice of her intention to resign 31 days thereafter. Ex. "A".

35. Abruptly, the same day after turning her notice in, she was asked to leave the facility, thus ending her active employment relationship that same day.

COUNT I

VIOLATION OF THE FALSE CLAIMS ACT

36. Paragraphs 1-35 are hereinafter realleged and incorporated by reference.

37. 31 U.S.C. 3729(a)(7) imposes liability upon any person who "knowingly makes, uses or causes to be made or used, a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property to the Government".

38. When a physician orders that a patient be placed under observation care, the patient's status is that of an outpatient. Such observation services are covered only when provided by the order of a physician or another individual authorized by state licensure law and hospital staff bylaws to admit patients to the hospital or to order outpatient tests. "In the majority of cases, the decision whether to discharge a patient from the hospital following resolution of the reason for the observation care or to admit the patient as an inpatient can be made in less than 48 hours, usually in less than 24 hours." Medicare Benefit Policy Manual, Chpt. 6 - Hospital Services Covered Under Part B, Rev. 90.06-19-08, 20.6, A. "Outpatient Services Defined".

39. All hospital observation services, regardless of the duration of the observation care, "that are medically and reasonably necessary" are covered by Medicare, based on hospital observation service, per hour. *Id*. At B, "Coverage of Outpatient Observation Services".

40. If the provider determines that the item or service meets the definition of observation services or

would otherwise be covered, then it must decide whether the item or service is "reasonable and necessary" for Medicare or the beneficiary to pay for. *Otherwise, the provider may be held liable for the cost of the item or service.* Id. at C, "Services Not Covered by Medicare and Notification To the Beneficiary", emphasis added. *See*: also, Medicare Claims Processing Manual, Pub. 100-4, Chpt. 4, Sections 290-290.6.

41. Lutheran has intentionally engaged in an orchestration to violate OIG Supplemental Compliance Program Guidance for Hospitals (Jan. 2005) with its unique "Blue Book" methodology and misinstruction to physicians concerning "One Day Stays".

42. That document instructs hospitals that a compliance risk exists since OIG is monitoring whether hospitals will attempt to circumvent the hospital outpatient payment system and encourages hospitals to become familiar with CMS policies. In December of 2005, CMS issued a Hospital Payment Monitoring Program (HPMP) Compliance Workbook replete with Standards, Instructions, Codes, Checklists, Audit Tools, Fact Sheets, Utilization Strategies, Status Guides, and websites to ensure hospital compliance with CMS policy.

43. Moreover, that Compliance Workbook is Chpt 8 - Part B - "Remedying Harm From Criminal Conduct And Effective Compliance And Ethics Program" from the 2004 Federal Sentencing Guidelines. Those guidelines clearly outline the need for organizations to: "1) exercise due diligence to prevent and detect criminal conduct... 2) otherwise promote an organizational cultures that encourages ethical

conduct and a commitment to compliance with the law...".

44. By not reporting nor correcting these problems with "23 hour observations" and "one day stays" which were not "medically necessary", CHS and Lutheran's silence was a false statement "to cancel, avoid, or decrease an obligation to pay or transmit money or properly to the Government" in violation of Section (a)(7).

COUNT II

VIOLATION OF 31 U.S.C. SECTION 3730(H) - WRONGFUL DISCHARGE

45. Paragraphs 1-44 are hereinafter realleged and incorporated by reference.

46. 31 U.S.C. Section 3730(h) states in pertinent part:

> Any employee who is discharged, demoted, suspended, threatened, harassed, or in any other manner discriminated against in the terms and conditions of employment by his or her employer because of the lawful acts done by the employee on behalf of the employee or others in furtherance of an action under this section, including investigation for, initiation of, testimony for, or assistance in an action filed, or to be filed under this section, shall be entitled to all relief necessary to make the employee whole.

47. To make a *prima facie* case for retaliatory discharge under 3730(h) in most jurisdictions, the Relator must show the following: (1) that she took acts in furtherance of a *qui tam* suit, *i.e.* engaged in

protected activity, (2) that her employer knew of the acts, and (3) that her employer discharged her as a result of these acts.

48. Reuille engaged in protected activity by repeatedly advising her supervisors that she believed that Lutheran had violated the law, by not appropriately addressing the problems associated with "23 Hour Observations" and "One Day Stays".

49. Reuille's supervisors and CHS and Lutheran operating management were aware of her concerns but took no action to remedy the ongoing filing of false claims.

50. On the date Reuille announced her constructive discharge to Lutheran and her intention to remain working for 30 more days to ensure a smooth transition of her duties, she was escorted from the building without explanation, though she was paid for the month of October, 2008.

51. Realizing the implications of what the hospital had done in light of the contents of Reuille's letter of resignation, during the week of November 17, 2008, Lutheran's Vice President of Human Resources contacted Reuille as she sought COBRA continuation coverage and (after filing for unemployment compensation insurance), informed her that there was "confusion" over her resignation, and that she remains on the hospital's payroll and is still covered by the Lutheran health care plan.

52. *Reuille was also told to have her undersigned counsel contact CHS corporate counsel to clear the matter up, return to work, and re-relate to Lutheran her concerns concerning fraudulent conduct which*

prompted her resignation, and sign a document that she will not engage in "whistle blower" activity.

53. Moreover, Lutheran has sent Reuille two (2) paychecks for the month of November along with correspondence which stated "this is a check-please cash". Reuille has not accepted the checks and as of this date is reminding Lutheran that she resigned on October 1, 2008, that her resignation was "accepted" by Malmstrom on that date, and is returning the checks.

54. In any event, the timing of her discharge, notable in light of failed EEOC settlement efforts a day prior thereto, demonstrates that her discharge was motivated by illegal animus prohibited by 31 U.S.C. 3730(h).

55. As a result of this discharge and not opting for re-employment, Reuille has sustained a loss of wages, emotional distress, and embarrassment.

PRAYER

WHEREFORE, Relator prays for judgment against Defendants as follows:

1. The Defendants cease and desist from violating 31 U.S.C. 3729-32;

2. That this Court enter judgment against the Defendants in an amount equal to three times the amount of damages the United States Government has sustained because of Defendants' actions, plus a civil penalty of not less than $5,000.00 and not more than $10,000.00 for each violation of 31 U.S.C. § 3729-32;

3. That Relator be awarded the maximum amount allowed pursuant to § 3730(d) of the False Claims Act.
4. That this Court enter judgment against Defendants pursuant to 31 U.S.C. § 3730(h) in an amount equal to two times Relator's accrued back pay, as of the date of entry of judgment, together with interest thereon, plus full damages for Relator's mental anguish, suffering and humiliation; that such judgment award Reuille full damages for future lost wages and benefits;
5. That Relator be awarded all costs and expenses of this action, including attorneys' fees; and
6. That Relator recover such other relief as the Court deems just and proper.

DISCLOSURE STATEMENT

I, Nancy Reuille, swear and affirm under the penalties of perjury that the above-foregoing statements are true, accurate and complete.

/s/ Nancy Reuille
Nancy Reuille

Respectfully submitted,

/s/ Loren Allison

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ATTORNEY FOR RELATOR

APPENDIX I

UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF TEXAS

TENET HEALTHCARE CORPORATION, Plaintiff, v. COMMUNITY HEALTH SYSTEMS, INC., WAYNE T. SMITH, and W. LARRY CASH, Defendants.	**CIVIL ACTION NO. 11-cv-732** **COMPLAINT FOR VIOLATIONS OF FEDERAL SECURITIES LAWS**

COMPLAINT

Plaintiff Tenet Healthcare Corporation ("Tenet"), by and through its undersigned attorneys, alleges as follows:

SUMMARY AND NATURE OF THE ACTION

1. This action seeks to compel Community Health Systems, Inc. ("CHS") to disclose fully its practice of systematically admitting, rather than

observing, patients in CHS hospitals for financial, rather than clinical, purposes. Tenet's shareholders are at risk of being harmed by false and misleading statements and omissions by CHS, a company whose financial performance has, for many years, been driven by the improper and undisclosed practice of systematically admitting patients into CHS hospitals despite no clinical need. CHS's practice of greatly underusing "observation" status and consequently overusing "inpatient admission" status has served to overstate its growth statistics, revenues, and profits, and has created a substantial undisclosed financial and legal liability to the federal government, numerous state governments, private insurance companies, and patients.

2. By failing to disclose its improper business practices and substantial liabilities, CHS has made false and misleading statements and material omissions to its own shareholders. Now, as CHS attempts to acquire Tenet for $6.00 per share, $1.00 of which would be paid in CHS stock to Tenet's shareholders, CHS is making false and misleading statements to Tenet's shareholders in the hope that they will exert pressure upon Tenet to accept an inadequate offer, or elect CHS-nominated directors who will approve a transaction with CHS. Since late 2010, for example, CHS has stated that a combined CHS-Tenet would benefit patients by "improv[ing the] quality of care" and benefit payers and employers by providing "cost-efficient" healthcare services. CHS has also claimed that there was "significant synergy potential" in its proposed acquisition of Tenet, similar to the synergies CHS claims to have achieved through its acquisition of other hospitals. CHS also has called itself an

"Industry Leader in Admissions Growth" since January 2011.

3. But what CHS has failed to disclose—and what has made CHS's proxy solicitation materials[1] materially misleading—is how CHS has managed to realize "synergies" from its hospital acquisitions: for at least a decade, CHS has implemented admissions criteria utilized by CHS physicians to systematically steer medically unnecessary inpatient admissions at CHS hospitals. CHS artificially increases inpatient admissions for the purpose of receiving substantially higher and unwarranted payments from Medicare and other sources. This admissions practice is the core "synergy" and driver of CHS's strategy for acquiring hospitals. Specifically, CHS has managed to improve the performance of its acquired hospitals not by growing the business, but by increasing margins through changing the acquired hospitals' admissions criteria and drastically lowering the rate at which its hospitals utilize "observation" status. To take just one example, CHS trumpets the synergies that it created through its 2007 acquisition of Triad Hospitals, Inc. ("Triad"), but what CHS does not disclose is that it achieved these synergies by slashing the use of observation at the former Triad hospitals by more than 50% in one year, and instead admitting those would-be observation patients, generating far greater revenue for the hospital. This undisclosed conduct violates both Medicare rules and

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[1] As set forth herein, the proxy solicitation materials at issue in this Complaint are CHS's SEC filings containing CHS's public statements made in support of its solicitation of proxies for the election of directors at Tenet's next annual meeting.

widely accepted standards of clinical care. It also subjects federal and state healthcare programs, insurance companies, local employers, and patients to excessive costs for needless hospital stays.

4. This improper admissions practice, which sets CHS apart from other peer hospital groups in the country, allowed CHS to receive approximately $280 million to $377 million, between 2006 and 2009, by treating Medicare patients on an admitted inpatient basis who should have been treated in observation. As a result, CHS has been paid by Medicare, and likely state Medicaid programs, private insurance companies, and other payers,[2] untold hundreds of millions—if not billions—of dollars for unnecessary hospital admissions. CHS may well be subject to liability and damages of well over $1 billion for its practices during the 2006-2009 period, not to mention damages to other payers and to the tens of thousands of patients who should never have been admitted as inpatients in CHS hospitals.[3]

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[2] The information set forth in this Complaint is based on public information relating to Medicare patients alone. There is no public information available on payments by other payers, but there is every reason to believe that patients covered by other payers also are subject to CHS's improper admissions practices.

[3] As set forth in detail below, if CHS had utilized observation at the same rate as the industry average, over 62,000 CHS Medicare patients would have been treated and billed as observation patients rather than admitted to the hospital and billed to Medicare as inpatients between 2006 and 2009. That number jumps to nearly 82,000 if CHS had observed patients at the same rate of another hospital operator, LifePoint. As a result of CHS physicians improperly admitting approximately 62,000-82,000 patients to CHS hospitals, CHS received approximately $280-$377 million between 2006 and 2009. Because the United States De-

CHS may even be subject to exclusion from participating in Medicare altogether, which could threaten the viability of the company entirely.

5. As a result of the revenues generated from these improper admissions, CHS's stock price has for many years been artificially inflated. CHS now seeks to use its artificially inflated stock price to pay, in part, for the proposed acquisition of Tenet.

6. Tenet, therefore, brings this action to compel CHS to disclose fully its admissions practices and the financial and legal risks inherent in them. Only through full disclosure can Tenet's shareholders appropriately evaluate the current CHS acquisition proposal or any subsequent proposals by CHS. Tenet also seeks to recover the substantial costs incurred in order to have CHS correct its misleading proxy solicitation materials.

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7. This litigation addresses core principles of patient care that CHS—and CHS alone among its peers in the industry—has fundamentally ignored in order to improve its own bottom line. CHS has placed profits before patients, and in so doing has placed its

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partment of Justice may impose treble damages for false Medicare claims, and the federal False Claims Act imposes a penalty of up to $11,000 per claim for improperly billed claims, CHS may face well over $1 billion in undisclosed liabilities—and this is only for Medicare Fee-for-Service patients, which made up approximately 27% of CHS's net operating revenue in 2010. These liabilities do not include CHS's potential liability to other payers who may have been harmed by CHS's admissions practices, including insurance companies, state Medicaid programs, employers, and patients.

future in peril. In particular, at the center of this litigation is an issue that hospitals and medical staff deal with every day: how a patient is appropriately treated at a hospital, and to the extent that patient is covered by Medicare, how that treatment should be billed to Medicare.

8. When a patient visits a hospital, physicians must determine, based on the severity of the patient's condition and expected treatment, whether the patient should be: i) admitted to the hospital for inpatient treatment; ii) observed as an outpatient for a period typically lasting up to 24 hours, but rarely more than 48 hours, before a decision can be made whether the patient requires hospital admission or may be discharged; or iii) provided treatment for minor conditions on an outpatient basis and then immediately discharged. The decision of whether to admit a patient or treat the patient in outpatient observation status has significant financial ramifications for the hospital.[4] Specifically, hospitals are paid substantially more by the Medicare program and certain other payers to treat a patient who has been billed as an admitted inpatient rather than one who has been billed as an outpatient in observation status. According to the Medicare Payment Advisory Commission (MedPAC), the independent Congressional agency that advises the U.S. Congress on issues affecting the Medicare program, for some patients, the Medicare program reimburses hospitals

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[4] As set forth in this Complaint, the analyses conducted by independent consultants essentially took all patients treated in a hospital bed, and measured which portion were billed as "observation" and which portion were billed as "admissions."

nearly $7,000 more per patient when the patient is admitted to the hospital as compared to treatment for the same patient in outpatient observation status.

9. Under federal law, Medicare reimburses hospitals only for treatment that is "reasonable and necessary for the diagnosis or treatment of illness or injury." 42 U.S.C. § 1395y(a)(1)(A). In addition, Medicare Administrative Contractors who process Medicare payments are prohibited from using Medicare funds to pay for services if those services were not "medically necessary, reasonable, and appropriate for the diagnosis and condition of the beneficiary." Medicare Program Integrity Manual, Chapter 6, Section 6.5.2. Similarly, under the Medicare Program Integrity Manual, "[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." *Id.*

10. Despite these Medicare provisions, CHS has developed admissions criteria that systematically steer patients into medically unnecessary inpatient admissions when those patients should be safely and effectively treated as outpatients in observation status. CHS accomplished this increase in patient admissions by implementing, in or around 2000, a home-grown set of patient admission criteria called the Blue Book, which was copyrighted in 2000 and is publicly available at the United States Copyright Office. The purpose of the Blue Book is simple: to provide a mechanism for CHS management to justify to its medical staff criteria for the admission of

patients who otherwise could have been observed and released.

11. Approximately three-quarters of hospitals in the country, including many publicly-traded hospital operators other than CHS, as well as nearly all major insurance companies, other payers and Medicare auditors, utilize one of two sets of independent, evidence-based, clinical criteria to determine whether a patient requires inpatient treatment or, instead, can be treated in outpatient observation status and/or discharged shortly after initial treatment at the hospital: i) the InterQual Criteria, developed by McKesson Corporation, which are used by approximately 60% of hospitals, and ii) the Milliman Care Guidelines, developed by Milliman, Inc., which are used by roughly 16% of hospitals. The Blue Book, on the other hand, is used only by CHS hospitals.

12. Rather than utilize the industry standard, objective criteria, however, CHS developed its now 40-page Blue Book, which was internally generated by CHS and lacks a single reference to a medical journal or other source. By way of comparison, the InterQual Criteria were developed by an independent panel of 1,100 physicians and medical providers, contain over 16,000 references to medical sources, and are used by 3,700 hospitals across the country. Development of the Milliman Care Guidelines, which have more than 15,000 medical references and are used by over 1,000 hospitals, was overseen by an experienced team of physicians and reviewed by approximately 100 independent doctors.

13. Since they are designed to maximize inpatient admissions, the Blue Book criteria are not

even "guidelines," but are a series of what the Blue Book calls "Admission Justification[s]" that are far more subjective and liberal than the evidence-based clinical criteria used by virtually all major hospital operators in the country. For countless common patient conditions, such as chest pain, syncope, pneumonia, gastrointestinal bleeding, and atrial fibrillation, the Blue Book sets forth far less rigorous (and clinically inappropriate) criteria for admitting a patient to the hospital than the industry standard criteria. Indeed, in many cases the Blue Book contains admissions criteria for which there is no clinical basis to admit the patient.

14. For example, under the Blue Book Admissions Justifications, a chest pain patient with nothing more than hypertension, and either shortness of breath, fatigue, sleeplessness and/or anxiety may be admitted to the telemetry unit of a CHS hospital. The Blue Book also justifies admission of a chest pain patient to the cardiac care unit ("CCU")—which is reserved for patients with the most critical medical conditions who require intensive and rapid treatment for survival—based on criteria that have no bearing on the severity of the patient's existing illness, but rather, address only the patient's medical history or conditions that are common among many chest pain patients. The InterQual Criteria, on the other hand, reject these liberal Blue Book Admission Justifications as a basis for admitting a patient to the hospital.

15. For another example, a patient with an irregular heartbeat, which may be caused by atrial fibrillation, may be admitted to the hospital under the Blue Book merely when the patient has high or

low potassium levels (common conditions easily treated at home or in observation) or when an X-ray shows increased heart silhouette, which typically results from a faulty X-ray and, in any event, has no bearing on the severity of a patient's atrial fibrillation. These symptoms and findings would not, under InterQual Criteria, warrant admitting a patient to the hospital.

16. The Blue Book also justifies the admission to CHS hospitals patients suffering from pneumonia even though the patient has nothing more than a cough and "rales" (fluid in the lungs), which exist for every patient with pneumonia. Again, the existence of a cough and rales in a patient gives no indication, standing alone, that it is medically necessary to admit that pneumonia patient to the hospital, rather than treating the patient in observation through IV antibiotics. And once again, a patient with a cough and rales would not, under the InterQual Criteria, be admitted to the hospital.

17. In each of these examples, and many more, the Blue Book Admission Justification criteria are at odds with standard clinical decision-making across the industry.

18. The purpose of CHS's liberal Blue Book criteria and admissions practices is clear: by admitting patients who, under accepted clinical criteria utilized throughout the hospital industry, should have been treated in observation or sent home, CHS receives substantially more money from Medicare than if the patient had been treated in outpatient observation status—an average of over $3,300—or 257%—more per patient for CHS's highest volume and lowest acuity inpatient admitted

patients. And as a result, taxpayers, insurers, businesses, and individuals have paid CHS hospitals more than they should for medical treatment.

19. According to an analysis of publicly available information on hospital observation rates, CHS's efforts to increase its revenue by driving up its admissions rate (with a corresponding decreased use of observation status) through the application of the Blue Book criteria have been very effective.[5] The analysis also shows that CHS's admission practices are unique in the hospital industry, as CHS's observation rate[6] is substantially lower than that of other publicly traded hospital systems, well-known

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[5] Following CHS's proposal to acquire Tenet for $6.00, made up of both cash and CHS stock, Tenet undertook an effort to understand more fully CHS's business practices and financial results. In particular, Tenet turned to two leading consulting firms, including the healthcare advisory firm Avalere Health LLC ("Avalere"), to study, based on publicly available data, how CHS's observation rate and related statistics compared to a number of publicly traded hospital systems, well-known non-publicly traded hospital systems, and the hospital industry as a whole. These consulting firms relied on separate data sources. One used data in the American Hospital Directory, while Avalere used the Centers for Medicare & Medicaid Services' ("CMS") Outpatient Standard Analytic Files ("SAFs") and Inpatient Prospective Payment System SAFs, which contains source data from which the Medicare Provider Analysis and Review ("MedPAR") database is constructed. Using these separate data sources, these consultants reached substantially similar conclusions. The observation data set forth in this Complaint were compiled through Avalere's analysis, which, again, used only publicly available data.

[6] Observation rate is the number of Medicare outpatient observation claims divided by the sum of Medicare outpatient observation claims plus Medicare inpatient claims.

non-publicly traded hospital systems, and the hospital industry as a whole.

20. Based on an analysis of Medicare claims data, the observation rate at CHS—the number of patients who are treated on an observation basis as a percentage of patients either admitted or observed—is approximately 60% less than the national average, and substantially below other publicly traded hospital systems and well-known non-publicly traded hospital systems. This means that a patient is far more likely to be treated in the higher-paying inpatient admission status, and far less likely to be treated in lower-paying observation status, if the patient visits a CHS hospital than if the patient visited a hospital operated by CHS's peers.

21. CHS's anomalous observation rate is not driven by a small number of CHS hospitals. Rather, 95% of CHS's short-term acute care hospitals have observation rates below the national average. And, as shown in detail below, CHS's low observation rate cannot be explained by the type of patients visiting CHS hospitals, by geographic considerations or by isolating specific types of hospital. In fact, when taking these factors into consideration, CHS actually should have an observation rate well in excess of the national average, rather than less than half the national average, but the observation data shows that exactly the opposite is true.

22. The statistical analysis and evaluation of CHS's business practices lead to a single, inescapable conclusion: patients whose medical needs likely required treatment in outpatient observation status were systematically admitted for higher-paying inpatient treatment at CHS hospitals.

23. CHS has reaped enormous sums through its admissions practices. Avalere, a leading healthcare advisory firm, estimates that, between 2006 and 2009, CHS received approximately $280 million to $377 million from treating inpatient admitted Medicare patients in CHS hospitals who—if CHS utilized observation status at the same rate as the national average or at that of another hospital system, LifePoint—would have been treated in observation rather than admitted to the hospital. As a result of CHS's admission practices with respect to these Medicare patients, CHS likely will be subject to significant damages. Under the federal False Claims Act, the United States Department of Justice may impose treble damages and a penalty of up to $11,000 per claim for false claims submitted to federal healthcare programs, meaning that CHS has potential exposure of well over $1 billion.

24. Critically, given that CHS's practices likely also impacted private insurance companies, state Medicaid programs, and other payers, not to mention the tens of thousands of patients who were unnecessarily admitted into a CHS hospital, CHS's improper revenue received from admitting Medicare patients may be just a fraction of the overall improper revenue received by CHS as a result of its admissions practices. To put CHS's potential liability to non-Medicare payers in perspective, in 2010, CHS earned approximately 27% of its net operating revenue from Medicare Fee-for-Service payments, or $3.4 billion. And moreover, these potential damages do not reflect the risk that CHS, based on its wide-ranging improper billing practices, may be excluded from participating in Medicare altogether.

25. In its effort to take control of Tenet, CHS has made numerous statements to Tenet shareholders in CHS's proxy solicitation materials that are false and/or misleading in light of CHS's failure to disclose its admissions practices. One prominent example is CHS's claims of success in realizing synergies from the acquisition of Triad in 2007, and statements that CHS would realize similar synergies with Tenet. CHS failed to disclose, however, that a potentially material portion of these supposed synergies with Triad were realized through CHS's systematic reduction in the observation rate at the former Triad hospitals—a stunning 52% drop in one year following the acquisition. CHS's oft-stated success in boosting profits through the Triad acquisition now appears to have resulted not simply from eliminating redundant overhead, but from implementing the inappropriate admissions criteria contained in the Blue Book.

26. Any similar synergies that CHS expects to realize from acquiring Tenet would, one can assume, be realized in exactly the same way as they were at Triad—by implementing CHS's Blue Book at the Tenet hospitals. These practices cannot be sustained, as the Department of Justice and Medicare auditors have devoted increased attention to investigating, auditing, and prosecuting hospitals that are improperly billing outpatient observation care as inpatient admissions. As health care fraud in general, and the use of observation status and "short stays" in particular, is a major focus areas for the federal government enforcement agencies and their recovery audit contractors ("RACs") in 2011, the likelihood of CHS's practices surviving undetected for several more months is remote.

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27. In light of CHS's acquisition proposal, beginning in November 2010, Tenet engaged in extensive analyses to assess the potential sources of operating "synergies," if any, that could result from combining CHS and Tenet, since such synergies would have a direct bearing on the value of Tenet to CHS. Tenet and its advisors found CHS's claims of synergies, as described on its December 10, 2010 investor call, difficult to substantiate. Indeed, of the sort of synergies described on that call—increased negotiating power with managed care companies—Tenet could only find one small market in which it believed this synergy might exist. Tenet was then informed by a third party that CHS applied overly-aggressive criteria to justify admitting patients to the hospital rather than having them observed and discharged, which created numerous disputes with payers. This information was consistent with CHS's recent statements on earnings calls that it had reclassified patients who had been admitted to the hospital for "one-day stays" to observation status. In order to more fully understand this issue, Tenet and its consultants performed the analyses discussed herein, using publicly available data for Medicare claims, of CHS's use of observation status.

28. Tenet now brings this action to compel CHS to correct its misstatements in its proxy solicitation materials so that Tenet's shareholders may more fully assess the value and likelihood of completion of CHS's current or subsequent offers. Absent injunctive relief, Tenet and its shareholders will be irreparably harmed, as any decision by Tenet's shareholders to approve or reject the slate of

directors nominated by CHS to replace the current Tenet Board will be based on less than full information about CHS due to its false and misleading statements and material omissions, which have artificially inflated CHS's stock price. And, separately, Tenet seeks to recover its significant costs incurred in investigating CHS's business practices and requiring CHS to correct its misstatements.

JURISDICTION AND VENUE

29. This Court has subject matter over this action pursuant to 15 U.S.C. §§ 78aa, 78m(d)(3), 78n(a), 28 U.S.C. § 1331.

30. Venue is proper in this District pursuant to 15 U.S.C. § 78aa and 28 U.S.C. § 1391.

31. Declaratory relief is appropriate pursuant to 28 U.S.C. § 2201 because an actual controversy exists regarding the propriety of Defendants' statements and disclosures under Section 14(a) of the Exchange Act, and SEC Rule 14a-9.

PARTIES

32. Plaintiff Tenet is a corporation incorporated under the laws of Nevada with its principal place of business at 1445 Ross Avenue, Dallas, Texas 75202. Tenet is a health care services company whose subsidiaries and affiliates operate general hospitals and related health care facilities, including 49 general hospitals and one critical access hospital in 11 states. Tenet employs approximately 57,500 personnel, including nearly 10,000 in Texas, and nearly 3,000 in the Dallas / Ft. Worth area.

33. Defendant CHS is a corporation incorporated under the laws of Delaware with its principal place of business at 4000 Meridian Boulevard, Franklin, Tennessee 37067. CHS provides healthcare services through 130 hospitals that it owns or leases in 29 states.

34. Defendant Wayne T. Smith is the Chairman and Chief Executive Officer of CHS, a position he has held since 1997.

35. Defendant W. Larry Cash is a member of the CHS Board of Directors and serves as the Chief Financial Officer of CHS, a position he has held since 1997.

CHS'S POLICY OF DRIVING ADMISSIONS GROWTH AND OVERBILLING MEDICARE

36. At the heart of the false and misleading statements in CHS's proxy solicitation materials is CHS's eschewal of certain fundamental principles of medical care: to treat patients according to their clinical needs, not the hospital's bottom line, and to be paid for only those services that are reasonable and medically necessary to serve the patient. The Medicare program operates fundamentally on an honor system yet, for at least a decade, CHS has turned its back on these basic principles and overcharged Medicare and other payers by at least hundreds of millions of dollars, in violation of Medicare regulations and widely accepted standards of patient care.

A. Background: Treating Patients According To Clinical Need

37. When a patient enters a hospital, physicians have three choices when it comes to treating the patient. First, for the most serious cases, a patient may be admitted to the hospital so that the patient may receive care that is expected to last for 24 hours or more. Second, when a patient's medical status does not necessarily require inpatient treatment, but additional monitoring and assessment is required to appropriately care for the patient, a patient is placed into outpatient "observation" status for care and monitoring that is expected to last less than 24 hours, but which may take as long as 48 hours if the physician is unable to make a determination within a 24-hour period. Observation patients are regularly assessed by hospital staff during the course of their stay—often receiving the identical care or treatment as patients who are admitted to the hospital—until the physician determines that there is no medical need for the patient to remain in the hospital or that the patient should be admitted. Third, for patients with relatively minor medical needs, physicians and nurses may provide treatment on an outpatient basis and discharge the patient without that patient being admitted into the hospital or placed into observation.

38. The use of observation status to treat patients is widely recognized as an essential tool for improving clinical decision making and providing cost effective medical care. Under the Medicare Benefit Policy Manual:

> Observation care is a well-defined set of specific, clinically appropriate services, which include

> ongoing short term treatment, assessment, and reassessment before a decision can be made regarding whether patients will require further treatment as hospital inpatients or if they are able to be discharged from the hospital. Observation services are commonly ordered for patients who present to the emergency department and who then require a significant period of treatment or monitoring in order to make a decision concerning their admission or discharge.

Medicare Benefit Policy Manual, Chapter 6, Section 20.6A.

39. There are several types of patients who should be placed in observation status rather than admitted to the hospital.[7] For example, observation care is appropriate for patients whose medical conditions (such as chest pain or abdominal pain) require diagnostic evaluation because i) the balance between the probability of the disease and the dangerousness of the disease warrants further evaluation; ii) the patient presents a condition that cannot be readily diagnosed without additional testing; or iii) the physician simply needs more time to evaluate the patient's symptoms to determine the most appropriate medical treatment.

40. Observation care also is appropriate for patients who require short-term treatment of

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[7] *See generally* Louis Graff, MD, *Principles of Observation Medicine*, *in* Observation Medicine (Louis Graff ed. 2010), *available at* http://www.acep.org/content.aspx?id=46142&terms=Observation%20Medicine.

emergent conditions. These are patients with conditions for which there is a high probability of therapeutic success with a limited amount of services, such as patients with asthma, dehydration, or an infection. In addition, patients who require therapeutic procedures that do not necessitate inpatient admissions, but who nonetheless require some period of hospital care, are best treated in observation. For certain procedures performed for therapeutic (such as transfusions) or diagnostic (such as angiograms) reasons, observation treatment can expedite the performance of these procedures.

41. The clearest beneficiaries of observation treatment are patients. When a patient is in observation, physicians may perform necessary testing or other procedures and then continually assess and reassess the patient's condition to determine whether the patient should be sent home or admitted to the hospital. Indeed, since many patients' conditions improve through quick, aggressive treatment, and because testing may eliminate serious risks and allow patients to return home, the vast majority of observation patients are sent home without ever being admitted to the hospital.[8]

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[8] *See* Society of Hospital Medicine's Expert Panel on Observation Units, Adrienne Green, MD, Chair, *The Observation Unit: An Operational Overview for the Hospitalist*,, *available at* http://www.hospitalmedicine.org/AM/Template.cfm?Section=White_Papers&Template=/CM/ContentDisplay.cfm&ContentID=21890; Louis Graff, MD, et al., Impact on the care of the emergency department chest pain patient from the chest pain evaluation registry (CHEPER) study, 80 Am. J. of Cardiology 563 (Sept. 1, 1997).

42. The other principal benefit of observation care is its cost effectiveness relative to inpatient treatment. With shorter stays and typically less testing and treatments for observation patients as compared to admitted patients, observation care can be very cost effective for payers. The decision of whether to treat a patient on an inpatient or outpatient observation basis has significant financial ramifications for the hospital. Indeed, according to the independent MedPAC, a hospital may receive Medicare reimbursement of nearly 1000% more (or approximately $7000 more per patient) for treatment and billing of an admitted chest pain patient on an inpatient admitted basis as compared to what the hospital would receive by treating and billing the patient in outpatient observation status.[9] Accordingly, hospitals have a strong financial incentive to improperly steer patients into admissions rather than treat patients appropriately on an observation basis and must employ safeguards to ensure their billing practices are appropriate.[10]

43. To combat this incentive, Medicare laws and guidelines prohibit hospitals from billing Medicare for treatment of a patient admitted to the hospital unless a physician, at the time the patient presents to the hospital, determines that the severity

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[9] Presentation, MedPAC, "Recent Growth in Hospital Observation Care" (Sept. 30, 2010), *available at* http://www.medpac.gov/transcripts/observation%20sept%202010.pdf.

[10] As explained below, extensive analysis of the available data demonstrates that CHS is the only major short term acute care, publicly traded hospital operator in the industry that has engaged in these unscrupulous admissions practices.

of the patient's condition requires care that the physician expects to meet or exceed 24 hours, and that placing the patient in a less intensive setting would significantly and directly threaten the patient's safety or health. *See* Medicare Benefit Policy Manual, Chapter 1, Section 10; Medicare Program Integrity Manual, Chapter 6, Section 6.5.2. In particular, under federal law, Medicare reimburses hospitals only for treatment that is "reasonable and necessary for the diagnosis or treatment of illness or injury." 42 U.S.C. § 1395y(a)(1)(A). In addition, Medicare intermediaries who make Medicare payments are prohibited under federal law from using Medicare funds to pay for services if those services were not "medically necessary, reasonable, and appropriate for the diagnosis and condition of the beneficiary." Medicare Program Integrity Manual, Chapter 6, Section 6.5.2. In sum, federal law and applicable Medicare guidelines establish that, absent a medical need to treat the patient on an inpatient basis, rather than in outpatient observation, Medicare is not responsible for payment of inpatient treatment.[11]

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[11] For example, one Medicare Contractor states in its coverage policy that "[c]ertain diagnoses and procedures generally do not support an inpatient admission, and fall within the definitions of outpatient observation. . . . Uncomplicated presentations of chest pain (rule out MI), mild asthma/COPD, mild CHF, syncope and decreased responsiveness, atrial arrhythmias and renal colic are all frequently associated with the expectation of a brief (less than 24-hour) stay unless serious pathology is uncovered." *See* Highmark Medicare Services, *Local Coverage Determination LCD L27548 – Acute Care: Inpatient, Observation and Treatment Room Services*, *available at* https://www.highmarkmedicareservices.com/policy/mac-ab/l27548-r4.html.

44. How CHS sought to evade these Medicare program requirements through developing and utilizing inappropriate inpatient admissions criteria, which resulted in admitting patients with no medical need for inpatient treatment, is at the heart of CHS's improper admissions practices.

B. CHS's Strategy Of Increasing Revenue Through Improper Patient Admissions

1. In Contravention of Medicare Rules, CHS Develops Admissions Criteria That Systematically Steer Medically Unnecessary Inpatient Admissions At Its Hospitals

a. CHS's Blue Book Criteria Have None Of The Attributes Of Criteria Used Throughout The Industry

45. Under Medicare regulations, hospitals are required to maintain a set of admissions criteria for determining whether a patient's condition is serious enough to warrant inpatient treatment. Such criteria are required to support treatment that is medically necessary. 42 C.F.R. § 482.30(c).

46. In or around 2000, CHS developed a set of admission criteria known as the "Blue Book" for CHS physicians and case managers to use in order to *justify* the admission of a patient into a CHS hospital.

47. Unlike the Blue Book, which is used only by CHS hospitals, the InterQual Criteria from McKesson Corporation was developed by an 1,100-member panel of independent physicians and medical professionals, and is used by approximately 3,700 hospitals, CMS, state Medicaid programs,

Medicare Quality Improvement Organizations in 40 states, and various Medicaid payers and private health plans. The InterQual Criteria are evidence-based, and, thus, contain over 16,000 references to medical literature in support of the clinical criteria by which physicians and other care providers determine whether a patient should be admitted to the hospital or treated on an outpatient observation basis.

48. Similarly, the Milliman Care Guidelines produced by Milliman, Inc. were overseen by an experienced team of physicians and reviewed by approximately 100 independent physicians before being released to the more than 1,000 hospitals and 1,800 Milliman clients, including 25 CMS auditors and seven of the eight largest U.S. health plans, who use them. Like InterQual, the Milliman Care Guidelines are evidence-based, and, as such, include references to over 15,000 medical journals, articles, textbooks, medical databases, and similar resources.

49. Together, InterQual and Milliman are used by approximately three-quarters of all hospitals in the United States, with approximately 60% using InterQual and approximately 16% using Milliman.

50. The Blue Book has none of the attributes of the industry standard InterQual or Milliman criteria. The Blue Book is merely a 40-page document that sets forth the "Admission Justification[s]" for the most common medical conditions presented by CHS patients. The Blue Book is not independent or objective, but rather was developed by CHS and, on information and belief, has never been externally tested by physicians unaffiliated with CHS. And, unlike InterQual or

Milliman, which are used by thousands of hospitals and other medical organizations across the country, the Blue Book lacks a single reference to a medical journal or other resource and is used only by CHS hospitals.

51. To educate CHS "case managers"—CHS-employed nurses responsible for administering the Blue Book at each of CHS's hospitals—on how to utilize the Blue Book criteria to "justify" admitting patients into the hospital, CHS developed a training presentation in which CHS acknowledges that its case managers have had reservations about applying the non-standard Blue Book admissions criteria to admit patients into the hospital.

52. For example, in a section of the training presentation entitled "Using The Blue Book," CHS warns that "[c]ase [m]anagers sometimes become overly concerned because we do not use InterQual criteria," and that "QIOs, managed care plans, and insurance companies will sometimes attempt to make you think that you must use their criteria." In these situations, case managers are instructed to "[p]olitely, but firmly, advise them that your hospital has adopted its own criteria and will use the same for its internal reviews."

53. Given that the Blue Book is designed to justify inpatient admissions, rather than properly equip physicians and nurses to treat patients according to their medical needs, it is of no surprise that this training presentation never once mentions the word "observation."

2. The Blue Book Admissions Justification Criteria Result In Admission Of Many Patients Who, Under Standard Clinical Practice, Would Ordinarily Be Placed Into Observation Status Or Sent Home

54. The Blue Book not only lacks medical references, independent testing or use outside of CHS, but its criteria for admitting patients into the hospital are demonstrably more lenient, general, and subjective than the evidence-based criteria used throughout the rest of the industry.

55. The Blue Book is organized around the most common patient conditions presented at CHS hospitals (*e.g.*, chest pain, asthma, and congestive heart failure). For each such condition, the Blue Book presents four categories of criteria to be applied by physicians and case managers at each stage of care: i) Admission Justification; ii) Ongoing Plan of Care; iii) Discharge Readiness; and iv) Documentation Guidelines.

56. The very structure of the Blue Book—with its focus on "Admission Justification"—demonstrates that it is not an objective set of criteria for determining whether it is more appropriate to treat a patient in observation or to admit the patient into the hospital. Indeed, there is but one reference to "observation status" in the entire Blue Book—for "very low risk chest pain."

57. As set forth below, for many conditions that are common among Medicare patients, the Blue Book includes admission justification criteria that bear little relevance to determining the severity of a

patient's condition, are at odds with standard clinical decision-making for determining the proper level of care for patient, and provide an improper clinical basis for admitting a patient into the hospital. Moreover, in many cases, the Blue Book simply fails to include the core criteria utilized by physicians to determine, for a given condition, whether the patient's presenting symptoms are serious enough to require admission into the hospital. A few of the more egregious Blue Book deficiencies are set forth below, which highlight the Blue Book's lack of clinical foundation for its flawed admissions justifications.

Chest Pain

58. The Blue Book's Admission Justifications criteria include several criteria that either are inappropriate or not relevant for physicians to consider in determining whether it is medically necessary to admit a chest pain patient to the hospital, where in the hospital the patient should be admitted and treated, or whether the patient should be treated in observation.

59. Under standard clinical practice, when a patient presents to the hospital with chest pains, there are varying levels of care that may be provided to the patient, depending on the severity of the patient's condition. Given that chest pain is a very non-specific complaint, meaning that there are many causes of chest pain other than a heart attack, patients often are initially evaluated in observation in order to determine whether or not they are in fact having a heart attack or suffering from a lack of oxygen to the heart. Many chest pain patients are appropriately treated in observation, where standard

tests may be run to determine whether the patient has had a heart attack, in which case the patient likely would be admitted to the hospital, and if not, the patient would likely be discharged. Once a decision is made to admit a patient to the hospital, there are varying levels of care in the hospital depending on the severity of the patient's clinical condition. The initial level of care for stable patients requiring admission is the inpatient general medicine or surgical floor setting. Those requiring a higher level of care may be placed in a telemetry or intermediate care setting. Lastly, those patients that are most critically ill may be placed in the critical care unit.

60. The Blue Book sets forth three levels of care, and two levels of admissions for chest pain patients, each with separate "Admissions Justifications": 1) "Very Low Risk: Observation or Discharge;" 2) "lower risk/telemetry (Green/Blue cases);" 3) "high and moderate risk levels/CCU (Orange/Red cases)." As set forth below, for each of these categories of care, the Blue Book contains admissions criteria that are both inappropriate and inconsistent with standard clinical decision-making.

Chest Pain Observation

61. When a patient presents to the hospital with chest pain—one of the most common presenting emergency room complaints—it is accepted clinical practice to run two to three sets of blood tests on the patient every six to eight hours to measure the levels of cardiac enzymes (specifically, a cardiac marker known as troponin) in the blood. An elevated troponin level from one test to the next indicates that the patient's cardiac wall likely has suffered a loss of

blood flow, meaning that the patient is at risk of suffering or having suffered a heart attack. If, as is often the case, the patient's troponin level does not increase from one blood test to the next, the physician may rule out a heart attack and send the patient home. In addition, it is standard practice to perform two electrocardiograms ("ECGs")—which measure changes in heart rhythm that may be indicative of a heart attack—during the same time period that the cardiac enzymes are measured.

62. Because these cardiac enzyme tests and ECGs may be completed in less than 24 hours, it is standard practice for these patients to be treated in observation, rather than admitted to the hospital. Indeed, treating chest pain patients in observation is so common that some hospitals have observation units dedicated solely to evaluating patients complaining of chest pain.

63. While it is standard clinical practice to run these tests while the patient is in observation, the Blue Book justifies placement of a patient in observation only *after* the patient has two negative serial ECGs and two negative sets of cardiac enzyme tests. In other words, under the Blue Book, these tests may be run on patients already admitted to the hospital.

Chest Pain Telemetry Admissions

64. The Blue Book Admission Justification criteria for chest pain, lower risk/telemetry are at odds with standard criteria used in practice and justify admissions where, under accepted practice, patients would not be admitted, but rather placed in observation or discharged. For example, a patient

with chest pain may be admitted to the telemetry unit rather than placed in observation if he or she merely has a general risk factor for cardiac disease (e.g. hypertension, diabetes, or hyperlipidemia) coupled with only one of the following:

i. New chest pain in the presence of a significant history of coronary artery disease;

ii. a recent visit to the hospital with complaints of chest pain;

iii. chest pain that may be reproduced by pressing on the chest; or

iv. "atypical symptoms," such as shortness of breath, fatigue, sleeplessness and/or anxiety.

65. These Admission Justification criteria are weighted toward admissions and are inconsistent with accepted clinical standards for inpatient admissions, however, because many patients who present with chest pain have a history of a cardiac risk factor, such as hypertension (a very common diagnosis in the U.S. population and not necessarily indicative of a medical need for inpatient care). Furthermore, the criteria identified in i.-iv. above are very different from the accepted clinical standards for hospital admission, such as having positive cardiac enzymes. For example, a "recent visit to the hospital with chest pain" is considered by the Blue Book to be a criterion for admission. While it is certainly a part of a patient's history, it is <u>not</u> any indication of a patient's clinical severity of illness. None of these criteria are representative of standard clinical criteria that physicians consider when

deciding whether to admit a patient with chest pain to the hospital. Under InterQual, moreover, these Blue Book criteria would not support the admission of a patient to the hospital.

Chest Pain CCU Admissions

66. The same is true for the Blue Book criteria for admission to the CCU. The CCU is reserved for patients with the most critical medical conditions who require intensive and rapid treatment for survival. The Blue Book Admissions Justification criteria, however, include many diagnoses that have no bearing on the severity of the patient's existing illness, but rather, address only the patient's medical history or conditions that are common among many chest pain patients—conditions that should have no bearing, under standard clinical practice, on whether a patient should be placed into the CCU rather than simply admitted to the general medical floor. For example, the Blue Book Admission Justification criteria for admission to the CCU include several criteria, two or more of which must be met to justify an admission to the CCU. Several of these criteria, however, are out of line with standard clinical decision-making, including the following:

i. A history of smoking, hypertension, hyperlipidemia, or diabetes;

ii. Two or more episodes of pain;

iii. Oxygen saturation less than 90;

iv. Rest angina less than 20 minutes (resolved with rest or nitrates); and

v. Indeterminant CKMB or Troponin.

67. Each of these criteria is not relevant to the determination of whether care in the CCU is medically necessary. For example, whether a patient is a smoker or has hypertension, for example, has no bearing on the severity of the patient's condition and certainly does not inform the need for CCU admission. Chest pain patients frequently present with two or more episodes of pain, meaning that this criteria is not indicative of the severity of a patient's chest pain necessary to require the highest level of care. Patients with an oxygen saturation less than 90 is extremely common, not in and of itself life threatening, and easily treatable with supplemental oxygen. When a short period of rest angina occurs and is resolved with rest or nitrate therapy, there is no medical necessity of treating such patients in an intensive care setting, which is reserved for the most critically ill patients. And whether the results of a patient's CKMB or troponin levels is "indeterminant" is not, under standard clinical practice, a justification for admitting the patient into the CCU, but rather, an indication that further testing should be performed.

* * * * *

68. In sum, in many cases where the Blue Book criteria inappropriately warrant a hospital admission for a chest pain patient, current accepted clinical practice standards justify placing the patient in observation status. In the case where patients present with chest pain, the standard of care through an electrocardiogram and cardiac enzyme blood testing may be used to determine whether or not a patient may be having a heart attack. If so, then patients may then be admitted to the appropriate

inpatient setting and appropriate level of care intensity. Patients that are ruled out for an acute heart attack, as the vast majority of "chest pain" patients are, may be discharged home.

Syncope Or Pre-Syncope

69. In addition, the Blue Book's Admissions Justifications include many criteria that are inappropriate for determining whether a patient with pre-syncope or syncope (dizziness or fainting) should be admitted to the hospital or should instead be treated in observation.

70. Under standard clinical practice, when a patient presents to the hospital complaining of dizziness (pre-syncope) or fainting (syncope), the physician performs several tests to eliminate any critical causes that may be responsible for these episodes, such as the potential for a heart attack, a stroke in the brain, or some form of structural heart disease or acute heart arrhythmia. These tests are standard in most hospital settings and can be performed within a 24-hour period. Such patients typically are placed in observation so that these critical, though rare, causes of syncope may be ruled out. Once they have been, syncope or pre-syncope is often due to dehydration (as determined by measuring a patient's drop in blood pressure between lying down and standing up) or by a vasovagal reaction (a very common cause of fainting in adults). Both of these etiologies are much less critical and can be treated simply in observation. Patients with dehydration will be rehydrated during their observation stay through IV fluids, and, as long as the syncope does not recur, will be sent home. Patients with vasovagal episodes will follow up with

their primary care physician as an outpatient, with further treatment if the episodes recur. Regardless, these patients typically are treated in observation.

71. The Blue Book Admission Justification criteria, however, call for the admission of a patient who has an episode of fainting and is over the age of 60. Age, however, is irrelevant in the case of syncope. Regardless of the etiology, age is not a risk factor for syncope, and all patients, regardless of age, will undergo the same workup and battery of testing discussed in the previous paragraph, which are appropriately conducted in observation. Additionally, the Blue Book admissions criteria include patients who have a "Postural BP greater than 15 mm," indicating that patients found to have a positive "orthostatic testing" (such as a drop in BP of great than 15 mmHg between a standing and sitting position) may be admitted. However, such a blood pressure drop is due to dehydration, which is something easily treated in an observation status with intravenous fluids and rehydration. Once again, this criterion is not a clinically accepted standard of care for determining whether it is medically necessary to admit a patient to the hospital.

72. In comparison, InterQual states that the criteria for observation are, as described above, pre-syncope or syncope of unknown etiology. This is appropriate and consistent with accepted standards of clinical care. Once a patient is found to have a more critical cause of syncope, such as structural heart disease or an arrhythmia, the InterQual Criteria indicate that it is reasonable to admit such patients to the hospital, but the majority of patients

are simply dehydrated, treated with IV fluids in observation, and discharged home.

Community Acquired Pneumonia ("CAP")

73. The Blue Book's Admission Justifications criteria ignore accepted clinical practices for determining whether a patient presenting with CAP is ill enough to require inpatient treatment, or whether the patient could, instead, appropriately be treated in observation.

74. Admission of a patient with CAP is justified under the Blue Book if the patient presents with a cough and rales (the presence of fluid in the lungs). But many patients who have pneumonia—regardless of severity—have the presence of a cough and rales on exam. Thus, the mere existence of these findings tells the physician nothing about whether a patient presenting with a cough and rales has a clinical picture that correlates with severity of illness requiring admission to the hospital.

75. Similarly, an admission of a patient with CAP is justified under the Blue Book if the patient presents with a cough and infiltrate or atelectasis. Again, the mere existence of a cough and abnormal chest X-ray is only relevant to informing the physician that the patient may have CAP; standing alone, the presence of these findings provides information on a possible diagnosis, but does not justify hospital admission. Clinical presentation, a critical component of the decision-making process regarding admission or observation, is not taken into account in the Blue Book.

76. Under the InterQual Criteria, patients presenting with a cough and rales or an abnormal

chest X-ray are not, absent other symptoms, admitted to the hospital for treatment. Instead, such patients would be examined to determine whether they have an elevated breathing rate, a fever, or a high white blood cell count, and most importantly, whether the patient is 65 or older. In the absence of serious additional criteria (for example, a breathing rate above 29), the patient would be treated in observation with IV antibiotics and monitored for up to 24 hours for improvement. In the typical case where the patient responded favorably to such treatment, the patient would be sent home, and if the condition worsened, the patient would be admitted to the hospital.

77. Finally, the Blue Book permits the admission of a CAP patient who presents with a cough and a temperature of 102 degrees with a white blood cell count of 15,000 or greater. It is well accepted, however, that a patient's temperature and white blood cell count—standing alone—do not necessarily have a strong correlation with the severity of disease without consideration of age and presence of co-morbidities. Thus, absent other factors (such as advanced age or a disease that weakens a patient's immune system), there is no absolute clinical basis for inpatient admission when a pneumonia patient has an elevated temperature and white blood cell count.

Atrial Fibrillation

78. The Blue Book Admission Justification criteria contain non-standard and clinically inappropriate justifications to admit patients with atrial fibrillation, which is an irregular beating of the heart.

79. For example, under the Blue Book, patients with an irregular heart beat may be admitted to the hospital if they also have potassium levels higher or lower than normal, or if a chest X-ray shows an "increased heart silhouette." But under standard clinical practice, neither of these factors bears any direct relation to determining whether or not a patient's atrial fibrillation is serious enough to warrant treatment as a hospital inpatient. Accordingly, neither of these criteria is included in the InterQual Criteria as a basis for admitting the patient to the hospital.

80. Patients in the hospital often present with abnormally low potassium levels—a condition that may be easily treated through a potassium supplement. Because, in most patients with normally functioning kidneys, potassium levels typically normalize within a few hours of treatment, atrial fibrillation patients with abnormal potassium levels may often be treated in observation and discharged within a few hours later when their condition improves. Under the Blue Book criteria, however, a patient with an irregular heartbeat and low potassium levels may be admitted to the hospital *before* receiving a simple potassium supplement. Such patients with only atrial fibrillation and abnormal potassium levels will typically recover within a few hours and be sent home, but will still be billed as an inpatient, as an observation stay.

81. An enlarged cardiac silhouette, another Blue Book criterion for atrial fibrillation admission, provides no basis for determining the severity of a patient's atrial fibrillation. The appearance of an enlarged heart silhouette is very non-specific and

may be artificially represented by poor X-ray technique, an overweight patient, or by patients who fail to take a deep breath during the X-ray. Thus, this criterion typically is not reflective of any medical condition, and, in any event, provides no basis for determining whether an atrial fibrillation patient should be admitted to the hospital rather than treated and monitored in observation or discharged to home with outpatient evaluation.

GI-Bleed

82. The Blue Book also fails to consider key criteria that are clinically necessary to determine whether it is medically necessary to admit to the hospital a patient presenting to the hospital with a gastrointestinal bleed (blood in the stool or vomitus).

83. The Blue Book ignores essential testing that, under standard clinical practice, must be performed so that medical staff may determine whether a patient's gastrointestinal bleeding is serious enough to require inpatient treatment or, instead, whether the patient may be treated with blood products and fluids in observation and monitored for improvement. Many patients who have stable hemoglobin levels over 24 hours of observation may be sent home and followed up as an outpatient with several tests to identify the source of bleeding. Alternatively, some patients may receive these tests within 24 hours of admission and be discharged home from observation once these tests are completed. Furthermore, it is standard for doctors to run tests to measure the patient's hemoglobin or hemotocrit (the concentration of red blood cells in the body), the rate of decrease of hemoglobin, and to check an International Normalized Ratio ("INR"), to

determine the "thinness" of the blood and the risk for further bleeding. Under both the InterQual Criteria and standard clinical practice, these tests largely determine whether a patient with gastrointestinal bleeding should be admitted to the hospital.

84. By ignoring these widely used tests, the Blue Book provides yet another clear, non-standard set of admission justifications to admit patients who, under standard practice, are most appropriately treated in observation with IV fluids and blood products, monitored, and discharged when their condition improves and hemoglobin has stabilized.

Cellulitis

85. The Blue Book's Admission Justification criteria also are deficient when applied to patients presenting with signs of cellulitis, an infection of the skin that can cause pain, fever, and elevated white blood cell counts.

86. For example, under the Blue Book, a patient presenting with a possible cellulitis and either an elevated white blood cell count and a temperature over 102 degrees, or a "weeping wound," may be admitted to the hospital. Again, these admission criteria fall outside accepted clinical practice as they individually do not provide evidence as to the severity of a patient's cellulitis. A patient presenting with only these conditions would not, under InterQual, be admitted to the hospital. Such patients would either be effectively treated with IV antibiotics in observation for 24 hours and discharged when their condition improved, as cellulitis often does with 24 hours of antibiotic treatment, or would be given one dose of IV

antibiotics in the emergency room and sent home with antibiotics by mouth and a follow up appointment soon after the ER visit.

87. What the Blue Book Admission Justification criteria altogether ignore is the critical question regarding complexity and severity of cellulitis, a question that doctors often face when determining whether a patient may be treated in observation or admitted to the hospital for treatment, and the length of time that would be required to treat a cellulitis patient with IV antibiotics. This determination is driven by the part of the body that is affected (cellulitis of the face, hand, or foot is more difficult to treat than the upper arm, thigh, or calf); co-existing medical conditions of the patient (patients with diabetes face greater risk associated with cellulitis, often supporting inpatient treatment); and signs of sepsis or shock (patients with low blood pressure, acute confusion, or bacteria in the blood are at the highest risk for complications). These widely accepted clinical factors are primary considerations under the InterQual admissions criteria, but under the Blue Book, less clinically relevant factors are considered to justify inpatient admissions.

88. Accordingly, the Blue Book not only presents overly general and non-clinical bases for admitting a cellulitis patient to the hospital, but omits several key criteria that physicians must consider to determine whether a patient's condition is serious enough to require inpatient treatment. These deficient Blue Book Admission Justifications, therefore, far more readily justify admitting a cellulitis patient as an inpatient than if the patient

were evaluated using accepted clinical criteria and practices.

3. CHS's Practice Of Billing Patients As Admitted Who Should Be Treated In Observation

89. As set forth above, the Blue Book contains far more subjective and liberal criteria for admitting patients into the hospital than accepted clinical decision-making and the evidence-based, clinical criteria used by peer hospital systems across the country. Thus, a patient who visits a CHS hospital is much more likely to be admitted into the hospital than if the same patient visited any other hospital that admits properly patients on the basis of clinical need.

90. CHS's underutilization of observation status derives not simply from the application of liberal Blue Book "Admission Justification" criteria. Rather, on information and belief, CHS has adopted a strategy of setting admission targets, incentivizing physicians to meet admission targets, and holding physicians and hospitals accountable for failure to meet those targets. For example, CHS sets targets for its hospitals for converting emergency room visitors into admitted patients. Upon information and belief, CHS physicians and Emergency Department ("ED") doctors working in CHS hospitals also receive bonuses based in part on the number of patients admitted to the hospital—part of CHS's goal of converting between 17% and 20% of all ED visits to inpatients. In establishing these artificial targets, CHS has ignored that patients should be admitted to the hospital from the ED based on their clinical

indications and needs, and not based on maximizing profits.

91. As a result, CHS has created a culture at its hospitals where patients are admitted by default and where observation is highly discouraged, even in cases where diagnostic testing or short term treatment is the medically appropriate and best course of care for the patient.

92. For example, patients who visit a CHS hospital through the ED frequently are inappropriately diagnosed with acute renal failure (and thus automatically admitted as inpatients) when they present with elevated creatinine levels. However, elevated creatinine levels often are present in cases of dehydration, a much less serious condition that does not typically necessitate admission. Thus, the accepted medical practice for patients with elevated creatinine levels is to place them in observation and give them fluids. If, as is typically the case, the patient's creatinine levels return to normal within 24 hours of receiving IV fluids, the physician can rule out acute renal failure and send the patient home. What CHS physicians often do for such patients, however, is admit them, rather than treat them with fluids in observation. Then, after the admitted patient has been treated with fluids and his or her creatinine levels have returned to normal within 24 hours, the patient is sent home. However, CHS still bills Medicare for an admitted patient under the initial diagnosis of acute renal failure, at a significantly higher cost than if the patient had, under standard clinical practices, been treated in observation.

93. Another example of the practice at CHS hospitals of admitting patients with symptoms best treated in observation status concerns patients presenting to the ED with chest pain, described in the previous section. Because the battery of tests run on virtually all chest pain patients may be completed in less than 24 hours, it is standard practice for these tests to be run on patients in observation status. At CHS hospitals, however, patients complaining of chest pain often are admitted to the hospital rather than treated in observation. If the clinical tests reveal that the patient has not had a heart attack, the patient will be discharged from the CHS hospital after only a short stay at the hospital (often only a single day), but that patient still will be billed to Medicare as an inpatient, at far greater cost than if the same treatment had been provided to the patient in observation.

94. In each of these examples, there is no medical need to admit the patient to the hospital. Indeed, the clinically appropriate decision is to place the patient into observation, run the necessary tests or provide the necessary treatment that will allow the physician to rule out the more serious condition, and then discharge the patient. In the event that the tests or treatment does not eliminate the more serious condition, the physician will then admit the patient to the hospital for further treatment. Through the Blue Book, CHS turns medical practice on its head by steering the admission of these patients immediately, quickly discharging the patients after tests and/or treatment rule out the serious condition, and then billing Medicare for the far more expensive—and wholly unnecessary—inpatient treatment.

95. In short, CHS has ignored Medicare rules by creating criteria and enforcing practices under which the admissions criteria applied by its physicians steer the physicians to inappropriately conclude that a patient's care requires inpatient admission, thus ignoring a clinically based standard of "reasonable and necessary" or "medically necessary" care.

96. As set forth in the following section, there is no question that, as a result of the admissions practices in place at CHS's hospitals, CHS has systematically underutilized observation status and, accordingly, CHS physicians have improperly admitted approximately 62,000 to 82,000 Medicare patients into CHS hospitals just in the years 2006-2009, and approximately 20,000 to 31,000 in 2009 alone.

4. CHS's Admissions Scheme Has Been Enormously Effective At Lowering Observation Rates And Increasing Admission Rates At CHS Hospitals

97. On its face, the Blue Book—with its non-objective, non-evidence based, and liberal criteria for admitting patients into hospitals—demonstrates that CHS is actively working to drive up inpatient admissions and drive down outpatient observation. When CHS's observation data is compared to the industry in general and to well-known hospital operators that compete with CHS, the full impact of this conduct is laid bare.[12]

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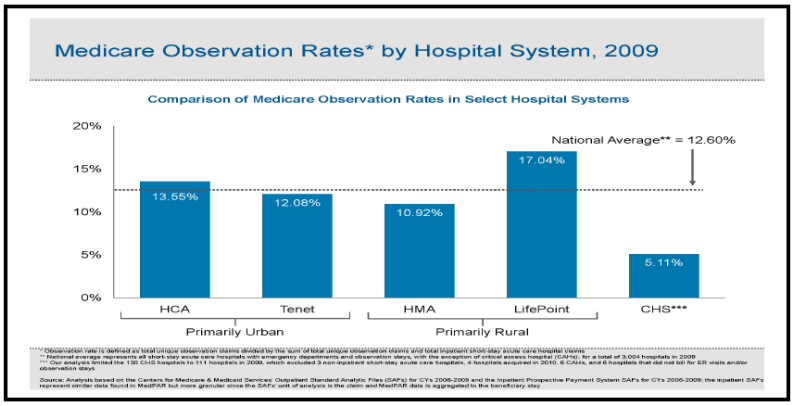
[12] The slides set forth in the remainder of this section of the Complaint were prepared by Avalere based on information con-

98. In 2009, for example (the last full year for which data are available), CHS's observation rate was less than half the industry average.[13]



99. CHS's low observation rate relative to the industry and its competitors is not driven by a small sample of CHS hospitals. To the contrary, nearly 95% of CHS's short-term acute care hospitals included in the analysis have observation rates below the national average, with nearly 70% of CHS's

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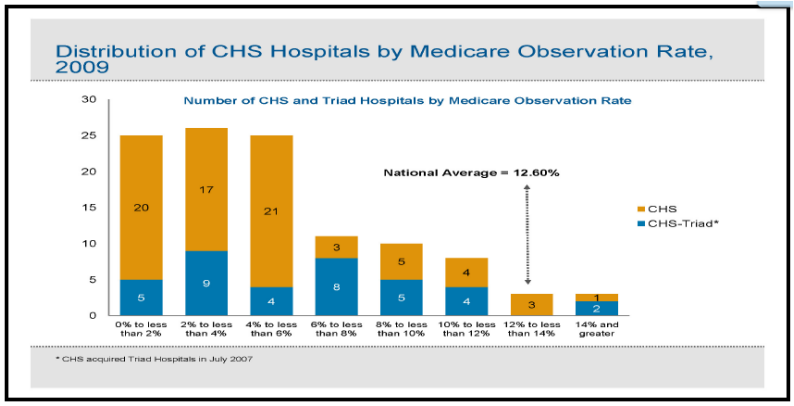
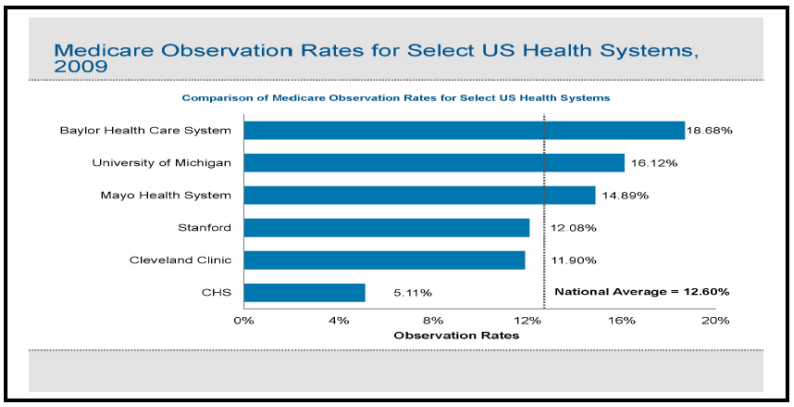
tained the CMS Outpatient SAFs and the Inpatient Prospective Payment System SAFs, the latter of which contains source data from which the MEDPAR database is constructed. As set forth in footnote 5 above, the conclusions set forth in these charts were independently reached by a separate consultant utilizing data from the American Hospital Directory.

[13] This analysis excluded from the hospital sample (including certain CHS hospitals) non-short term acute care hospitals (*i.e.*, psychiatric, children's, long term, and rehabilitation), critical access hospitals, and hospitals that did not bill for emergency department visits and/or observation. Because the last full year for which data is available is 2009, the CHS hospitals included in the analysis do not include four CHS hospitals acquired in 2010.

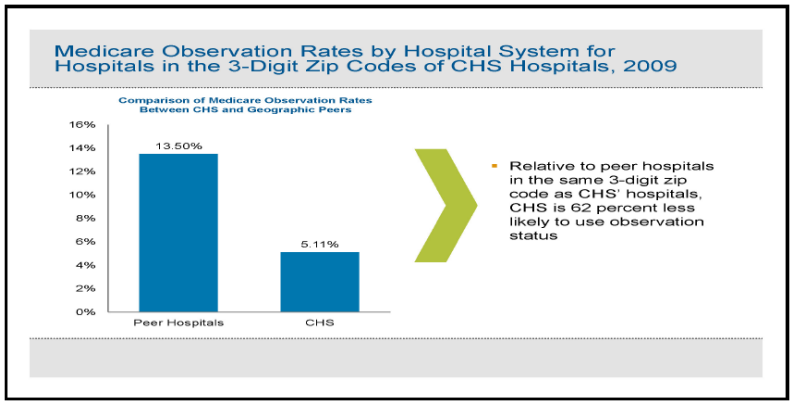
hospitals falling more than 50% below the national average.



100. CHS's observation rate also is significantly below the rates at some of the most highly respected not-for-profit hospitals in the country.



101. CHS's rural hospital base in no way explains its low observation rate relative to the industry, since hospitals in the immediate vicinity of CHS have a substantially higher observation rate than CHS hospitals.



102. CHS's low observation rate relative to the industry also does not vary based on the type of CHS facility included in the sample.[14]

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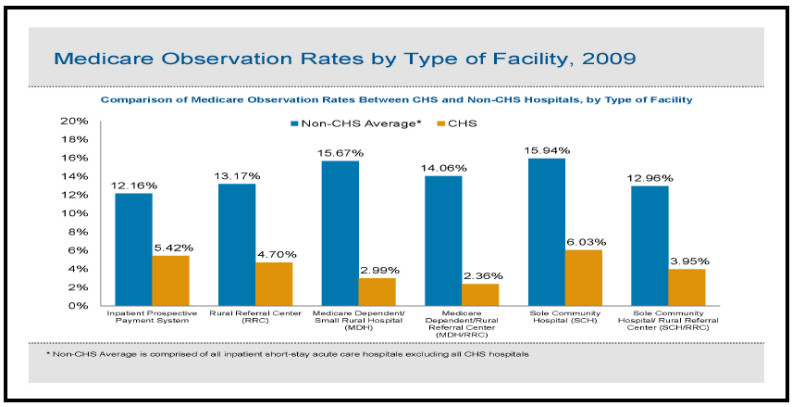
[14] Inpatient Prospective Payment System ("IPPS") hospitals receive fixed payments for acute care hospital stays, based on prospectively set rates. A Medicare Dependent Rural Hospital ("MDRH") is (1) located in a rural area; (2) has no more than 100 beds; (3) is not classified as a Sole Community Hospital ("SCH"); and (4) has at least 60 percent of inpatient days or discharges covered by Medicare. A Medicare Dependent (Non-Rural) Hospital meets criteria 2-4 in the previous sentence. An SCH is (1) 35 miles from a like hospital; (2) between 15 and 25 miles from a like hospital and nearby hospitals have been inaccessible for at least 30 days in 2 out of 3 years due to weather or local topography; or (3) is between 25 and 35 miles from a like hospital and either (a) has fewer than 50 beds, (b) nearby hospitals have been inaccessible for at least 30 days in 2 out of 3 years due to weather or local topography, or (c) no more than 25 percent of all inpatients or inpatient Medicare beneficiaries in



103. CHS's use of its Blue Book criteria to improperly drive up admissions and drive down observation rates is most apparent through CHS's acquisition of Triad's hospitals in 2007. As set forth in the tables below, in 2006—before the acquisition—Triad's observation rate far exceeded CHS's rate.

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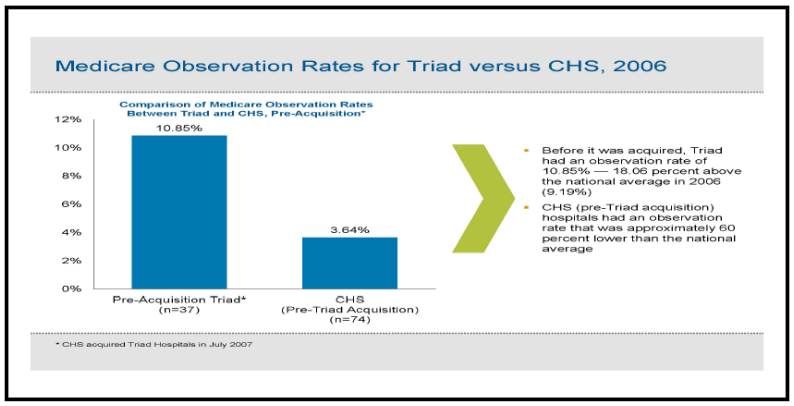
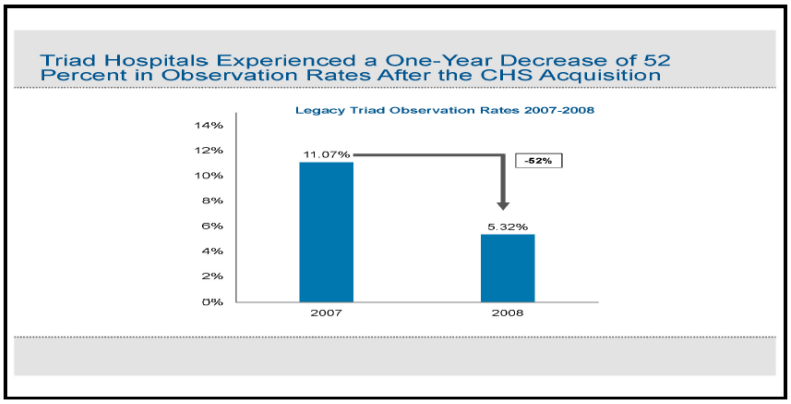
its service area are admitted to other like hospitals within 35 miles. A SCH (Rural) is a SCH located in a rural area. Finally, a hospital qualifies as a Rural Referral Center ("RRC") if it (1) has at least 275 beds; (2) demonstrates that at least 50 percent of Medicare patients are referred from other hospitals or from physicians not on the hospital staff, at least 60 percent of Medicare patients live more than 25 miles away, and at least 60 percent of the Medicare services it furnishes are provided to beneficiaries who live more than 25 miles away; or (3) demonstrates that it has a case-mix index value greater than or equal to the median for all urban hospitals in the same census region, and has at least 5,000 discharges per year (3,000 for osteopathic hospitals) or at least the median number of discharges for urban hospitals in the same region, and either (a) more than 50 percent of its medical staff are specialists; (b) at least 60 percent of its discharges are for inpatients residing more than 25 miles away, and (c) at least 40 percent of its inpatients are referred from other hospitals or from physicians not on the hospital staff.



104. But within a year of CHS's acquisition of Triad, CHS had drastically reduced the observation rate at the former Triad hospitals through the implementation of its Blue Book admissions practices.



105. According to industry data, moreover, CHS sees lower acuity patients than the national average. Specifically, the average CHS hospital has a lower case mix index ("CMI") (1.28) than the national average inpatient short-stay acute care hospital (1.43). Hospitals with lower CMI are expected to have a higher observation rate, but CHS has a lower than average observation rate and a lower than

average CMI. That CHS's observation rate is so low despite its lower acuity patients further demonstrates the extent of CHS's improper admissions practices.

106. Thus, under any measure, CHS's improper practices to inflate inpatient admissions and drive down observation rates at its hospitals, thus creating excessive revenues and profits, have been remarkably effective.

5. CHS's Admissions Practices Result In At Least Hundreds Of Millions Of Dollars In Improper Billings

107. CHS has billed substantial excess sums by driving admissions upward. Taking only CHS's highest volume and lowest acuity inpatient admitted Medicare patients, CHS receives on average over $3,300—or 257%—more per admitted patient than it would receive if these patients were treated in observation.

108. CHS's efforts to inflate the admissions rate and decrease the observation rate at its hospitals have been remarkably profitable. In the years 2006 to 2009, CHS has provided inpatient care to between approximately 62,000 and 82,000 Medicare patients who, under industry standard clinical criteria, likely would have been treated in observation. The treatment of these Medicare patients on an inpatient basis has resulted in CHS receiving between $280 million and $377 million. The net incremental revenue that CHS billed through this admissions practice is a significant, unsustainable, and improper source of revenue to CHS.

109. But these improper revenues likely represent only a fraction of the total benefit that CHS has received through improper billings, since CHS's liberalized admission criteria have undoubtedly resulted in similarly improper billings to private payers and to state Medicare and Medicaid programs.

110. Given CHS's effectiveness in implementing its admission criteria across its hospitals, CHS's financial goals now depend on finding more hospitals that it can acquire so that CHS can sustain the practice of driving down observation rates and driving up admission rates through the use of the Blue Book—just like CHS did through its acquisition of Triad. Accordingly, CHS has now set its sights on Tenet, whose observation rate is approximately at the national average.

CHS: THE SERIAL HOSPITAL ACQUIRER

111. For over a decade, CHS has steadfastly adhered to an operational strategy of acquiring hospitals and increasing revenue from these hospitals by immediately lowering their observation rates and increasing inpatient admission rates through its wrongful practices.

112. CHS's strategy of growth-through-acquisition is best illustrated through its 2007 acquisition of Plano, Texas based Triad, which operated 49 hospitals in 17 states, including 11 hospitals in Texas. After acquiring Triad, CHS eliminated 85% of the former Triad headquarters employees. Immediately following the acquisition, the vast majority of the former Triad hospitals were forced to adopt CHS's non-standard Blue Book

criteria—and reject the InterQual Criteria used by most Triad hospitals—for determining whether a patient should be admitted into the hospital or, instead, treated on an observation basis. The immediate impact of CHS's Blue Book practices on Triad's hospitals was stunning: within one year of the acquisition, the observation rate at the former Triad hospitals that had been incorporated into CHS dropped 52%, a direct result of CHS improperly admitting into hospitals patients who, under Triad's pre-acquisition admissions criteria, would have been appropriately treated on an observation basis.

113. The problem for CHS, however, is that its admissions practices cannot continue because the Department of Justice and Medicare auditors have looked with increased scrutiny on hospitals with high one-day stays—which are red flags for patients who should have been treated on an outpatient observation basis rather than admitted to the hospital. For example, since 2007, the Department of Justice has announced at least four multi-million dollar settlements with hospitals over improper billing of observation patients as admissions. This enhanced scrutiny of improper hospital billing also has been driven by CMS, which recently substantially expanded nationwide the use of Recovery Audit Contractors or "RACs"—auditors who are paid a contingency fee to identify improper Medicare billings by hospitals.

114. For the last six quarters, moreover, CHS has announced that it had reclassified patients as observation who had been billed as admitted for

"one-day stays."[15] CHS also has disclosed in SEC filings that its hospital in Laredo, Texas is being investigated by the Office of Inspector General of the U.S. Department of Health and Human Services, which has requested documents related to matters including "case management, resource management, admission criteria, patient medical records, coding [and] billing…" And in February 2011, CHS announced that each of its 18 Texas hospitals were under investigation by the Texas Attorney General concerning "emergency department procedures and billing."

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[15] *See, e.g.*, Q1 2009 Earnings Call (Larry Cash: "Additionally, we did see a decline in one-day stays that affects inpatient volume and a corresponding increase in outpatient observation visits."); Q1 2010 Earnings Call (Larry Cash: "Reductions in one-day stays with a corresponding increase in outpatient observations of 50BPS" contributed to a decline in same-store volume.); Q2 2010 Earnings Call (Larry Cash announced a "reduction in one-day admissions with a corresponding increase in outpatient observations" and "movement of the one-day stays to observations."); Q3 2010 Earnings Call (Larry Cash: "Again, soft volumes continued throughout the third quarter. The following contributed to the decline . . . reductions in one-day stays with the corresponding increase in outpatient observations of 70 basis points."); Q4 2010 Earnings Call (Larry Cash announced that for the fourth quarter of 2010 "[r]eductions in one-day stays for corresponding increase in outpatient observations are 100 basis points" and, in 2010, total "movement of one-day stays to observation was 70 basis points.").

CHS SETS ITS SIGHTS ON TENET AS ITS NEXT ACQUISITION TARGET

A. CHS Makes An Unsolicited, Inadequate Offer To Acquire Tenet

115. On November 12, 2010, Wayne Smith of CHS sent a letter to Tenet's President and Chief Executive Officer, Trevor Fetter, and the Tenet Board of Directors making an unsolicited offer to acquire all of the outstanding shares of Tenet for $6.00 per share in cash and stock. Smith indicated his belief that any such merger would present a "compelling strategic combination" based on, among other things, CHS's "ability to leverage the operating efficiencies and best practices of a combined organization."

B. After Careful Consideration, The Tenet Board Rejects CHS's Inadequate Bid

116. Tenet's Board of Directors, in consultation with its financial and legal advisors, unanimously determined that CHS's proposal was not in the best interest of Tenet or its shareholders.

C. CHS Goes Public With Its Acquisition Proposal And Commences Its Proxy Solicitation Process

117. On December 9, 2010, the day after receiving Tenet's rejection, CHS issued a press release, which it filed with the SEC as proxy solicitation materials,[16] announcing that it had made

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[16] CHS filed the press release with the SEC pursuant to Rule 425 of the Securities Act of 1933. Materials filed under Rule 425 also are deemed filed as proxy solicitation materials under Rule

an offer to acquire Tenet for $6.00 per share in cash and stock, and that the Tenet Board of Directors had declined to accept that offer. The press release stressed CHS's "reputation for superior operating performance" and "successful track record of integrating acquisitions." CHS also stated in the press release that its proposal was "strategically compelling" because, among other things, the "operating efficiencies and best practices of a combined organization would enable it to provide even higher quality care for patients . . ." With its press release, CHS also filed with the SEC a presentation entitled "Community Health Systems and Tenet Healthcare: A Compelling Opportunity for Value Creation," which outlined CHS's rationale for seeking to acquire Tenet.

118. The following day, on December 10, 2010, CHS hosted an analyst call in which Wayne Smith made various statements about the proposed deal, including that there was "significant synergy potential" in a combined CHS-Tenet.

119. Since CHS's announcement of its proposal on December 9, 2010, more than 680 million shares of Tenet's stock have traded. Moreover, in every trading day, Tenet's stock has traded well above CHS's $6.00 per share offer price.

14a-12 of the Securities and Exchange Act of 1934. In particular, Note 2 to Rule 425 under the Securities Act of 1933 states: "No filing is required under Rule 13e-4(c), Rule 14a-12(b), Rule 14d-2(b), or Rule 14d-9(a), if the communication is filed under this section. Communications filed under this section also are deemed filed under the other applicable sections."

D. CHS Launches A Proxy Solicitation Contest To Replace Tenet's Board

120. On December 20, 2010 CHS issued a press release, which it filed with the SEC as proxy solicitation materials pursuant to Rule 425 of the Securities Act of 1933 and Rule 14a-12 of the Securities Exchange Act of 1934, announcing that CHS planned to nominate directors for election at the 2011 Tenet annual meeting. The press release quoted Wayne Smith as stating that CHS was convinced of the "powerful logic" of the proposed acquisition and was "fully committed to completing" the acquisition.

121. On January 12, 2011, CHS filed with the SEC as proxy solicitation materials, pursuant to Rule 425 of the Securities Act of 1933 and Rule 14a-12 of the Securities Exchange Act of 1934, a presentation delivered by Wayne Smith on January 11, 2011 at the JP Morgan Investor Conference in San Francisco, California (the "January 12th Proxy Solicitation").

122. Two days later, on January 14, 2011, CHS issued a press release, which it filed with the SEC as proxy solicitation materials, pursuant to Rule 425 of the Securities Act of 1933 and Rule 14a-12 of the Securities Exchange Act of 1934, announcing a slate of ten directors that CHS said it intended to nominate to replace Tenet's ten-member Board at Tenet's November 3, 2011 annual meeting.

123. On February 8, 2011, Wayne Smith delivered a presentation at the UBS Global Healthcare Services Conference, a portion of which remarks were filed with the SEC as proxy

solicitation materials, pursuant to Rule 425 of the Securities Act of 1933 and Rule 14a-12 of the Securities Exchange Act of 1934.

124. On February 24, 2011, CHS issued a press release, which it filed with the SEC as proxy solicitation materials, pursuant to Rule 425 of the Securities Act of 1933 and Rule 14a-12 of the Securities Exchange Act of 1934, announcing its earnings for the fourth quarter of 2010. The following day, CHS hosted a teleconference with investment analysts to discuss CHS's quarterly earnings. On February 28, 2011, CHS filed excerpts of the earnings call transcript with the SEC as proxy solicitation materials, again pursuant to Rule 425 of the Securities Act of 1933 and Rule 14a-12 of the Securities Exchange Act of 1934.

125. On March 1, 2011, CHS filed with the SEC as proxy solicitation materials, pursuant to Rule 425 of the Securities Act of 1933 and Rule 14a-12 of the Securities Exchange Act of 1934, a presentation delivered by Wayne Smith at the Citi Global Healthcare Conference, and excerpts of the remarks delivered by Smith at the conference.

126. On March 2, 2011, CHS filed with the SEC as proxy solicitation materials, pursuant to Rule 425 of the Securities Act of 1933 and Rule 14a-12 of the Securities Exchange Act of 1934, excerpts of remarks by Wayne Smith and Larry Cash at the March 2, 2011 RBC Capital Markets Healthcare Conference.

MATERIAL MISSTATEMENTS AND OMISSIONS IN CHS'S PROXY SOLICITATION MATERIALS

A. CHS's December 9th Press Release And Presentation Filed With The SEC Contained Numerous Material Misstatements And Omissions

127. On December 9, 2010, CHS filed with the SEC a press release announcing its proposal to acquire Tenet for $6.00 per share in cash and CHS stock. In the press release, which was filed with the SEC, CHS stated, among other things, that the combination of CHS and Tenet was both "financially and strategically compelling" because Tenet would be accretive to CHS's earning per share in the first full year after closing. In addition, the press release stated that CHS had a "reputation for superior operating performance and a successful track record of integrating acquisitions." CHS also stated that its "ability to enhance the operating efficiencies and best practices of a combined organization would enable it to provide even higher quality for patients . . ."

128. CHS attached as an exhibit to its press release a copy of a presentation entitled "Community Health Systems and Tenet Healthcare: A Compelling Opportunity For Value Creation."[17] In that presentation, CHS made several of the same

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[17] In this filing, CHS acknowledged that "The Company and its directors and executive officers and other persons may be deemed to be participants in any solicitation of proxies from Tenet's stockholders in respect of the proposed transaction with Tenet . . ."

statements contained in its press release. The presentation contained additional statements about the purported value of a combined CHS-Tenet, including "significant synergy potential" between CHS and Tenet. The presentation further touted CHS's success in integrating Triad's hospitals and that, if the transaction were approved, Tenet's shareholders would receive a portion of the transaction consideration in the form of CHS stock. According to CHS, this meant that Tenet's shareholders would have the opportunity "participate in future upside from earnings growth and synergy realization." CHS also stated that the "Transaction Benefits Key Constituents," including patients, who would experience "[i]mproved quality of care from standardized best practices and clinical protocols," and payers/employers, who would receive a "[c]omprehensive range of healthcare services provided in a cost-efficient manner." With respect to the Triad acquisition, CHS stated that it had improved Triad's margins and achieved "peak synergies" of over $275 million.

129. These statements were materially false and/or misleading in light of CHS's failure to disclose that, for at least a decade, the number of patients admitted into CHS hospitals was the product of CHS's unsustainable admissions practices, discussed in detail above, to steer patients into inpatient treatment despite the absence of any clinical basis for these patients to be admitted into the hospital. Specifically, CHS failed to disclose that CHS had engaged in an effort to increase its patient admissions through implementation of the improper admission practices that resulted in the admission of patients into CHS hospitals who, under industry

standard clinical criteria, should have been treated in observation. CHS's purported reputation as a successful operator and acquirer was based on this same improper conduct.

130. Moreover, CHS's statement that a combined CHS-Tenet would provide even higher quality healthcare for patients was false and misleading in light of these same material omissions about CHS's admissions practices. In fact, a combined CHS-Tenet would provide worse healthcare because, if CHS were able to successfully implement its Blue Book practices at Tenet, just as CHS had done with the former Triad hospitals, even more patients would be improperly admitted into hospitals for unnecessary treatment, exposing Medicare and other payers to improper additional costs.

131. These statements also were materially false and/or misleading in light of CHS's failure to disclose that its results after acquiring Triad were driven by CHS's implementation of its admissions practices at former Triad hospitals, discussed in detail above, to steer patients into inpatient treatment despite the absence of any clinical basis for these patients to be admitted into the hospital.

132. These statements were further materially false and misleading because CHS failed to disclose that Tenet shareholders would be subjected to significant undisclosed financial risk if the transaction were approved, because the performance of a combined CHS-Tenet would depend on CHS's ability to implement the unsustainable Blue Book admissions. Thus, the transaction was not "financially and strategically compelling" or accretive to EPS because CHS's practices could not possibly

continue. Nor did CHS disclose that, as a result of these undisclosed liabilities and in light of the substantial revenue generated through its admissions practices, CHS's financial statements were false and would have to be restated.

133. In addition, CHS's statement that the inclusion of CHS stock as consideration to Tenet's shareholders would benefit Tenet's shareholders was false and misleading. Given CHS's undisclosed business practices and liabilities, CHS's stock price has been and continues to be artificially inflated. Thus, the value of CHS's stock is worth less than the $1 per share being offered by CHS as part of the acquisition.

134. These materially false and misleading statements and omissions by CHS and Smith are part of a continuous plan to encourage Tenet shareholders, under false pretenses, to elect the CHS slate of directors at Tenet's next annual meeting on November 3, 2011.

135. Defendants' materially false and misleading statements discussed above constitute a violation of Section 14(a) of the Exchange Act and Rule 14a-9.

B. CHS And Defendants Smith And Cash Made Numerous Material Misstatements And Omissions During The December 10th Analyst Call

136. On December 10, 2010, CHS hosted an analyst call in which Defendants Smith and Cash made many of the same misstatements about the proposed deal as contained in CHS's press release and investor presentation filed with the SEC on December 9, 2010. In addition, Smith touted CHS's

"proven track record of unmatched operating performance," including through CHS's acquisition of Triad, which CHS "successfully integrated." In particular, Smith claimed that CHS was able to effectively integrate Triad because "we have a very standardized, centralized platform, operating platform. And the more we add to the platform, the more productivity and the more efficiency we get." Smith asserted that these same "corporate synergies and operating synergies" would occur in any Tenet acquisition. Cash, referencing CHS's purported success with the Triad acquisition, stated that "$275 million [in synergies] can probably be achieved" in any acquisition of Tenet. Moreover, Smith stated that "[p]rior to the execution of a definitive agreement, we will receive a financing commitment to fully fund this transaction."

137. These statements were materially false and/or misleading in light of the same material omissions concerning CHS's Blue Book admissions practices set forth above. In addition, these statements were materially false and misleading because Defendants failed to disclose that Tenet shareholders would be subjected to significant undisclosed financial risk if the transaction were approved, because the performance of a combined CHS-Tenet would depend on CHS's ability to implement the unsustainable Blue Book admissions practices and avoid prosecution. Thus, the transaction was not "fair" to Tenet shareholders or "financially and strategically compelling" and accretive to EPS because the transaction was dependent upon CHS continuing its unsustainable Blue Book admissions practices. Smith's statement that CHS would be able to raise sufficient funds to

finance the transaction also was false and misleading. Given the magnitude of CHS's undisclosed business practices and liabilities, it is highly unlikely that CHS will be able to raise sufficient funds to finance the cash portion of the transaction once the truth concerning CHS's admissions practices comes to light.

138. These material false and misleading statements and omissions by CHS, Smith, and Cash are part of a continuous plan to encourage Tenet shareholders, under false pretenses, to elect the CHS slate of directors at Tenet's next annual meeting on November 3, 2011.

139. Defendants' materially false and misleading statements discussed above constitute a violation of Section 14(a) of the Exchange Act and Rule 14a-9.

C. CHS's December 20th Press Release Contained Numerous Material Misstatements And Omissions

140. On December 20, 2010, CHS issued a press release, which it filed with the SEC, announcing that it intended to nominate directors for election at Tenet's 2011 annual meeting. The press release quoted Wayne Smith as saying that CHS was convinced of the "powerful logic of combining CHS and Tenet," and that any such combination was "strategically and financially compelling."

141. These statements were materially false and/or misleading in light of CHS's material omissions concerning its Blue Book admissions practices discussed in detail above.

142. These material false and misleading statements and omissions by CHS and Smith are

part of a continuous plan to encourage Tenet shareholders, under false pretenses, to elect the CHS slate of directors at Tenet's next annual meeting on November 3, 2011.

143. Defendants' materially false and misleading statements discussed above constitute a violation of Section 14(a) of the Exchange Act and Rule 14a-9.

D. CHS's January 12th Solicitation And Statements By Smith During The Investor Conference Were Materially False And Misleading

144. On January 12, 2011, CHS filed with the SEC,[18] a complete copy of the presentation delivered by defendant Wayne Smith at the JP Morgan Investor Conference on January 11, 2011. It contained numerous materially false and misleading statements and omissions, as set forth below.

1. Statements About CHS's Admissions Growth, ER Strategy, and Operating Strategy

145. In the January 12th Proxy Solicitation, CHS stated that it is an "Industry Leader in Admissions Growth," and provided data purporting to reflect that CHS's admissions and adjusted patient admissions had grown in every year from 2000 to 2009. In addition, CHS stated that one of its "Significant Opportunities for Growth in Revenue and Operating Profit" is to "Increase Inpatient ER Visits." CHS further stated that its "ER Strategy"

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[18] This filing, according to CHS, was "deemed filed pursuant to Rule 14a-12 under the Securities Exchange Act of 1934."

has "[c]ontributed to same store admission growth." Moreover, with regard to its operating strategy, CHS made statements about its purported success at "Improv[ing] Hospital Operations" through "Standardization and Centralization," including CHS's "Billing and Collections" and "Quality/Resource/Case Management" functions. During Wayne Smith's January 11, 2011 presentation, moreover, Smith stated that CHS had a "very sound operating strategy," a "very clear executable strategy, [that] is predictable, [and] is sustainable, as we've proven over the last ten years," and a "proven operating formula and strategy that works with consistent financial performance and margin improvement."

146. These statements were materially false and/or misleading in light of CHS's failure to disclose that its admissions numbers, ER strategy, and operating strategy depended on CHS's improper admissions practices, discussed in detail above. In particular, for at least a decade, the number of patients admitted into CHS hospitals was the product of CHS's unsustainable admissions practice of steering patients into inpatient treatment despite the absence of any clinical basis for these patients to be admitted into the hospital. Specifically, CHS failed to disclose that CHS had engaged in a systemic practice of increasing its patient admissions through implementation of the Blue Book criteria that resulted in the admission of patients into CHS hospitals who, under industry standard clinical criteria, should have been treated in observation.

147. These materially false and misleading statements and omissions by CHS and Smith are

part of a continuous plan to encourage Tenet shareholders, under false pretenses, to elect the CHS slate of directors at Tenet's next annual meeting on November 3, 2011.

148. Defendants' materially false and misleading statements discussed above constitute a violation of Section 14(a) of the Exchange Act and Rule 14a-9.

2. False and Misleading Statements And Omissions About CHS's Acquisition of Triad

149. During Wayne Smith's January 11, 2011 presentation at the JP Morgan Investor Conference, Smith made affirmative statements about CHS's success as an acquirer of hospitals, and in particular, CHS's purported success in acquiring and integrating hospitals acquired in from Triad in 2007. In particular, Smith stated:

> We get a lot of questions around synergies and about all we can tell you is—and this is what we always tell you is what we have done in the past and how we performed. But if you look at what happened, the Triad facilities, we've improved the margin about 280 basis points and we got about $275 million of synergies out of those facilities.

150. In addition, in the January 12th Proxy Solicitation, CHS provided data that purported to show, on a revenue and EBITDA basis, that hospitals acquired by CHS performed better after being acquired by CHS. CHS further stated in the January 12th Proxy Solicitation that "CHS Management Significantly Improved Triad's Operating Results," and that CHS had "[s]uccessfully

integrated [the] Triad acquisition." In particular, as Smith indicated during his presentation, the proxy statement claimed that CHS had improved Triad's margins by 280 basis points in the two years following the acquisition, and that CHS had achieved over $275 million in "Peak Synergies" from the Triad acquisition.

151. These statements were materially false and/or misleading in light of CHS's failure to disclose that its results after acquiring Triad were driven by CHS implementing its admissions practices at former Triad hospitals, discussed in detail above, to steer patients into inpatient treatment despite the absence of a clinical basis for these patients to be admitted into the hospital.

152. These materially false and misleading statements and omissions by CHS and Smith are part of a continuous plan to encourage Tenet shareholders, under false pretenses, to elect the CHS slate of directors at Tenet's next annual meeting on November 3, 2011.

153. Defendants' materially false and misleading statements discussed above constitute a violation of Section 14(a) of the Exchange Act and Rule 14a-9.

3. Statements About The Value Of CHS's Proposal To Acquire Tenet

154. In the January 12th Proxy Solicitation, CHS made affirmative statements about the purported value of a CHS-Tenet combined entity, many of which misstatements also were made in CHS's earlier proxy solicitation materials. In particular, CHS stated that there was a "Compelling Strategic Rationale" for its proposed acquisition of

Tenet because, among other things, there was a "[s]trong complementary fit with significant synergy potential," an "[o]pportunity to leverage operating efficiencies and best practices," and the "[t]ransaction is accretive to EPS in the first full year." Moreover, CHS stated that it had made an "Attractive Offer for Tenet Shareholders," and that the inclusion of "[s]tock consideration provides Tenet shareholders the opportunity to participate in future upside from earnings growth and synergy realization." Similarly, during Wayne Smith's January 11, 2011 presentation, he stated that CHS had made a "very attractive offer" to Tenet and that "there is a clear opportunity both in margin improvement and there is clear opportunity for synergies in this acquisition going forward."

155. These statements were materially false and/or misleading in light of CHS's failure to disclose its Blue Book admissions practices, discussed in detail above. In addition, since CHS's proposal to acquire Tenet included CHS stock, Tenet's shareholders would become CHS shareholders if the deal were consummated pursuant to CHS's proposal. CHS's Blue Book practices inflated CHS's financial results by at least hundreds of millions of dollars, and accordingly, rendered CHS's financial statements false and misleading. As a result, the value of the stock component of the consideration being offered by CHS is artificially inflated, and the true value of the CHS stock component of the consideration is something less than $1.00. Thus, the statements by CHS and Mr. Smith about the value to Tenet shareholders associated with their ownership of CHS stock were materially false and misleading.

156. Moreover, CHS's assertions to Tenet shareholders that there was a "Compelling Strategic Rationale" for CHS's proposed deal and that the proposal was an "Attractive Offer for Tenet Shareholders" were materially false and misleading in light of CHS's failure to disclose its business practices that were at the core of CHS's acquisition "success" and the "synergies" that it would purportedly realize by acquiring Tenet, and that have resulted in artificial inflation in the price of CHS's stock.

157. These materially false and misleading statements and omissions by CHS and Smith are part of a continuous plan to encourage Tenet shareholders, under false pretenses, to elect the CHS slate of directors at Tenet's next annual meeting on November 3, 2011.

158. Defendants' materially false and misleading statements discussed above constitute a violation of Section 14(a) of the Exchange Act and Rule 14a-9.

4. Statements About CHS's Financial Results

159. In the January 12th Proxy Solicitation, CHS made statements concerning CHS's financial performance, including CHS's revenue, EBITDA, EBITDA margin, and earnings per share, among other metrics. CHS also stated that "Community Health's Strategy Has Delivered Results," and included a chart that purported to show CHS's revenue and EBITDA increasing nearly every year between 1996 and 2009.

160. These statements were materially false and/or misleading in light of CHS's failure to disclose

its Blue Book admissions practices, discussed in detail above. Between 2006 and 2009, these practices have netted CHS approximately $280 million to $377 million in improper billings related to admitted Medicare patients, and likely resulted in substantial additional revenues from similarly improper billings to insurance companies, states, and other payers, and have created the potential for enormous undisclosed fines and penalties and the risk of exclusion from the Medicare program.

161. These materially false and misleading statements and omissions by CHS and Smith are part of a continuous plan to encourage Tenet shareholders, under false pretenses, to elect the CHS slate of directors at Tenet's next annual meeting on November 3, 2011.

162. Defendants' failure to disclose material information about CHS's unsustainable practices to increase patient admissions and inclusion of false and misleading financial results in the January 12th Proxy Solicitation constitutes a violation of Section 14(a) of the Exchange Act and SEC Rule 14a-9.

E. CHS's February 8th Proxy Solicitation, Including Statements By Smith, Contained Numerous Material Misstatements And Omissions

163. On February 8, 2011, Wayne Smith delivered a presentation at the UBS Global Healthcare Services Conference. That same day, CHS filed excerpts of Wayne Smith's remarks at the UBS conference with the SEC. These materials contained numerous materially false and misleading statements, similar to those contained in early proxy

solicitation materials from CHS. For example, in the February 8th proxy solicitation materials, Wayne Smith touted CHS's ability to improve margins and performance in its acquired hospitals, citing the Triad acquisition as the primary example. Smith also referred to the supposed "synergies" CHS achieved in the Triad acquisition and asserted that, with respect to Tenet, there "is a lot of opportunity in terms of the synergies."

164. These statements were materially false and/or misleading in light of CHS's failure to disclose that its results after acquiring Triad were driven by CHS implementing its admissions practices at former Triad hospitals, discussed in detail above, to steer patients into inpatient treatment despite the absence of a clinical basis for these patients to be admitted into the hospital, and that any synergies CHS would realize from its acquisition of Tenet would depend on CHS implementing the same admissions practices.

165. These materially false and misleading statements and omissions by CHS and Smith are part of a continuous plan to encourage Tenet shareholders, under false pretenses, to elect the CHS slate of directors at Tenet's next annual meeting on November 3, 2011.

166. Defendants' materially false and misleading statements discussed above constitute a violation of Section 14(a) of the Exchange Act and Rule 14a-9.

F. CHS's February 24th Press Release And Statements By Smith And Cash During The Earnings Call Were Materially False And Misleading And Contained Numerous Material Omissions

167. On February 24, 2011, CHS issued an earnings release that it filed with the SEC. The following day, CHS hosted an earnings call with investment analysts. The earnings release and statements made by Wayne Smith and Larry Cash during the earnings call were materially false and misleading in light of many of the material omissions discussed in detail above.

168. For example, during the analyst call, Smith and Cash also made materially false and misleading statements about patient admissions and observation status. Specifically, Smith stated that there was a "national trend" of moving patients who had been billed as inpatients to observation, due to increased pressure from payers to "reduce costs." Smith stated that, for some insurance companies, "the payment on observation is essentially the same as when [patients] stay [in the hospital]. So the economics on it sometimes are not all that different." Smith further stated that the movement of patients billed as admitted to observation is "an industry-wide issue and I don't see it as anything that's problematic for us. It's just a change in location basically."

169. These statements were materially false and misleading in light of Defendants' failure to disclose that CHS was far more vulnerable than its peers to pressure from payers to shift admitted patients to observation status in light of undisclosed CHS's

admissions practices, which resulted in CHS vastly underutilizing observation status as compared to CHS's peer hospital operators. These statements also were materially false and misleading because, contrary to Smith's statements and suggestion that there was little difference in cost to the payer between billing a patient as inpatient and billing the same patient as observation and that the difference between an admission and observation is merely a difference of "location," the difference for CHS of billing a patient as an admitted inpatient and billing a patient in observation is substantial. CHS earns an average of over $3,300—or 257%—more per patient for CHS's highest volume and lowest acuity admitted Medicare patients than CHS would earn if these patients had been treated in observation, and for many patients, the spread is far higher. These statements are also materially false and misleading because of Smith's failure to disclose the very material risk of improper billing under Medicare, in particular, that under Medicare there is an enormous difference in payments between observation and inpatient status, and that the penalties for improperly billing Medicare include treble damages and a penalty of up to $11,000 per false claim, plus the risk of exclusion from the Medicare program.

170. Smith also made statements during the earnings call concerning CHS's "success as an operator and consolidator in the industry," that CHS had "continued to focus on improving performance at the individual hospital level in all of our markets, especially at our most recently acquired facilities," and that CHS had "proven operational efficiencies." These statements were materially false and

misleading in light of CHS's failure to disclose that its success as an acquirer, its operational performance and its "efficiencies" were dependent upon its undisclosed and unsustainable admissions practices discussed in detail above.

171. In addition, CHS's financial results and performance data reported in the earnings release and analyst call—including CHS's reported increase in total admissions of 0.1 percent and 2.5 percent increase in total adjusted admissions compared to 2009—were materially false and misleading in light of Defendants' failure to disclose that CHS's financial results and admissions numbers were dependent upon CHS's improper admissions practices.

172. These materially false and misleading statements and material omissions by CHS, Smith and Cash are part of a continuous plan to encourage Tenet shareholders, under false pretenses, to elect the CHS slate of directors at Tenet's next annual meeting on November 3, 2011.

173. Defendants' materially false and misleading statements discussed above constitute a violation of Section 14(a) of the Exchange Act and Rule 14a-9.

G. CHS's March 1st Proxy Solicitation Contained Materially False And Misleading Statements

174. On March 1, 2011, Wayne Smith delivered a presentation at the Citi Global Healthcare Conference. That same day, CHS filed with the SEC a copy of the presentation and excerpts of Wayne Smith's remarks at the conference. These materials contained numerous materially false and misleading statements, similar to those contained in early proxy

solicitation materials from CHS. Indeed, the presentation was virtually identical to the presentation delivered by Wayne Smith at the JP Morgan Investor Conference on January 11, 2011, which CHS filed with the SEC as proxy solicitation materials, and therefore contains all of the same materially false and misleading statements and omissions as the January 11th proxy solicitation, discussed in detail above. In addition, during his remarks at the Citi Global Healthcare Conference, Wayne Smith touted CHS's ability to improve margins and performance in its acquired hospitals, citing the Triad acquisition as the primary example.

175. These statements were materially false and/or misleading in light of Defendants' failure to disclose that its results after acquiring Triad were driven by CHS implementing its admissions practices at former Triad hospitals, discussed in detail above.

176. These materially false and misleading statements and material omissions by CHS and Smith are part of a continuous plan to encourage Tenet shareholders, under false pretenses, to elect the CHS slate of directors at Tenet's next annual meeting on November 3, 2011.

177. Defendants' materially false and misleading statements discussed above constitute a violation of Section 14(a) of the Exchange Act and Rule 14a-9.

H. CHS's March 2nd Proxy Solicitation Contained Materially False And Misleading Statements And Material Omissions

178. On March 2, 2011, Wayne Smith and Larry Cash spoke at the RBC Capital Markets Healthcare

Conference. That same day, CHS filed with the SEC excerpts of Smith's and Cash's remarks at the conference. During the conference, Smith and Cash made several of the same materially false and misleading statements as had been made in previous proxy solicitations by Defendants. Specifically, Smith and Cash touted the CHS's ability to improve margins and performance in its acquired hospitals, citing the supposed "synergies" that CHS realized through the Triad acquisition as the primary example, and asserting that CHS would realize similar synergies by acquiring Tenet.

179. These statements were materially false and/or misleading in light of Defendants' failure to disclose that its results after acquiring Triad were driven by CHS implementing its admissions practices at former Triad hospitals, discussed in detail above, and that CHS's ability to realize similar synergies by acquiring Tenet depended on its ability to implement the same improper and unsustainable admissions practices.

180. These materially false and misleading statements and omissions by CHS and Smith are part of a continuous plan to encourage Tenet shareholders, under false pretenses, to elect the CHS slate of directors at Tenet's next annual meeting on November 3, 2011.

181. Defendants' materially false and misleading statements discussed above constitute a violation of Section 14(a) of the Exchange Act and Rule 14a-9.

COUNT I

(Violation of 15 U.S.C. 78n(a) (Section 14(a) of the Securities and Exchange Act of 1934) and 17 C.F.R. § 240.14a-9)

182. Tenet repeats and realleges each and every allegation set forth in paragraphs 1 to 181 as if fully set forth herein.

183. This Count is brought against Defendants CHS, Smith, and Cash.

184. CHS's proxy solicitation materials and statements made by Defendants Smith and Cash in connection with the solicitation of proxies are all subject to regulation under Section 14 of the Exchange Act. Among other things, Section 14, also known as the Williams Act, regulates proxy solicitations. Specifically, SEC Rule 14a-9 applies to Defendants' proxy solicitations and provides that "[n]o solicitation . . . shall be made by means of any proxy statement, form of proxy, notice of meeting or other communication, written or oral, containing any statement which, at the time and in the light of the circumstances under which it is made, is false or misleading with respect to any material fact, or which omits to state any material fact necessary in order to make the statements therein not false or misleading . . . ."

185. As described above, the Defendants' proxy solicitations and statements related thereto contained numerous materially false and/or misleading statements and omissions of material facts in violation of Section 14(a) of the Exchange Act and SEC Rule 14a-9.

186. The materially false and misleading misstatements and omissions in Defendants' proxy solicitations and statements related thereto were made with at least a negligent state of mind, as required under Section 14(a) of the Exchange Act and SEC Rule 14a-9.

187. If left uncorrected, the materially false and misleading misstatements and omissions in Defendants' proxy solicitations and statements related thereto will deprive Tenet's shareholders of the opportunity to make decisions with respect to the election of directors at the next Tenet annual meeting based on the materially accurate information to which they are entitled. Accordingly, both Tenet and its shareholders will be irreparably harmed.

188. Tenet has no adequate remedy at law.

189. Accordingly, Tenet is entitled to: (a) a declaration that the Defendants' proxy solicitations violate Section 14(a) of the Exchange Act and SEC Rule 14a-9; (b) an order requiring the Defendants to correct by public means the material misstatements and omissions in their proxy solicitations; and (c) a permanent injunction preventing the Defendants from making any additional material misstatements or omissions in connection with, or otherwise related to, proxy battles or shareholder votes or consent solicitations with respect to Tenet.

COUNT II

(Violation of 15 U.S.C. 78n(a) (Section 14(a) of the Securities and Exchange Act of 1934) and 17 C.F.R. § 240.14a-9)

190. Tenet repeats and realleges each and every allegation set forth in paragraphs 1 to 189 as if fully set forth herein.

191. This Count is brought against Defendants CHS, Smith, and Cash.

192. CHS's proxy solicitation materials and statements made by Defendants Smith and Cash in connection with the solicitation of proxies are all subject to regulation under Section 14 of the Exchange Act. Among other things, Section 14, also known as the Williams Act, regulates proxy solicitations. Specifically, SEC Rule 14a-9 applies to Defendants' proxy solicitations and provides that "[n]o solicitation . . . shall be made by means of any proxy statement, form of proxy, notice of meeting or other communication, written or oral, containing any statement which, at the time and in the light of the circumstances under which it is made, is false or misleading with respect to any material fact, or which omits to state any material fact necessary in order to make the statements therein not false or misleading . . . ."

193. As described above, the Defendants' proxy solicitations and statements related thereto contained numerous material false and/or misleading statements and omissions of material facts in violation of Section 14(a) of the Exchange Act and SEC Rule 14a-9.

194. The materially false and misleading misstatements and omissions in Defendants' proxy solicitations and statements related thereto were made with at least a negligent state of mind, as required under Section 14(a) of the Exchange Act and SEC Rule 14a-9.

195. Tenet incurred significant costs investigating the fraudulent nature of Defendants' proxy solicitations and statements related thereto.

196. Accordingly, Tenet is entitled to damages in the amount of the costs that it incurred in investigating CHS's undisclosed conduct that made Defendants' proxy solicitations and statements related thereto false and/or misleading.

COUNT III

(Violation of 15 U.S.C. 78j(b) and 17 C.F.R. 240.10b-5 – Section 10(b) and Rule 10b-5 of the Securities and Exchange Act of 1934)

197. Tenet repeats and realleges each and every allegation set forth in paragraphs 1 to 196 as if fully set forth herein.

198. This Count is brought against Defendants CHS, Smith, and Cash.

199. CHS's public filings and public statements made by Defendants Smith and Cash about CHS are subject to regulation under Section 10(b) of the Exchange Act and SEC Rule 10b-5 promulgated thereunder. Specifically, SEC Rule 10b-5(b) makes it unlawful, in connection with the purchase or sale of securities, for "any person, directly or indirectly, . . . [t]o make any untrue statement of a material fact or

to omit to state a material fact necessary in order to make the statements made, in light of the circumstances under which they were made, not misleading."

200. As described above, Defendants, and each of them, intentionally or recklessly made numerous materially false and/or misleading statements and omissions of material facts in violation of Section 10(b) of the Exchange Act and SEC Rule 10b-5. Specifically, Defendants, and each of them, made these statements and omissions with the intent to inflate the market price of CHS stock in order to make CHS's offer price for Tenet (with consideration consisting partially of CHS stock) appear more valuable to Tenet and its shareholders. Defendants, and each of them, knew or recklessly disregarded that their statements and omissions made to Tenet and its shareholders were false and misleading. Moreover, Defendants Smith and Cash approved and/or signed CHS's public filings (including financial statements and proxy solicitation materials) with the intent of artificially inflating the market price of CHS stock.

201. Tenet and its shareholders have relied upon, and will continue to rely upon, the artificially inflated market price of CHS stock when determining whether to vote to elect a slate of directors at Tenet's next annual meeting, which slate of directors would vote to approve a transaction by which CHS would acquire Tenet and Tenet's shareholders would acquire artificially inflated CHS stock.

202. Defendants' materially false and misleading misstatements and omissions were intended to, did,

and, absent injunctive and/or declaratory relief, will continue to directly and proximately cause the following: (i) artificially inflating the price of CHS stock, (ii) depriving Tenet's shareholders the opportunity to make decisions with respect to the election of directors at the next Tenet annual meeting with the benefit of materially accurate information to which they are entitled, and (iii) subjecting Tenet and its shareholders to the risk that CHS will consummate its acquisition of Tenet at a below-market price. Accordingly, absent injunctive relief, Tenet and its shareholders will be irreparably harmed.

203. Tenet has no adequate remedy at law.

204. Accordingly, Tenet is entitled to: (a) a declaration that the public statements by Defendants described in this Complaint violate Section 10(b) of the Exchange Act and SEC Rule 10b-5; and (b) a permanent injunction preventing Defendants from making any additional material misstatements or omissions in connection with, or otherwise related to, Defendants' admissions practices.

COUNT IV

(Violation of 15 U.S.C. 78t(a) – Section 20(a) of the Securities and Exchange Act of 1934)

205. Tenet repeats and realleges each and every allegation set forth in paragraphs 1 to 204 as if fully set forth herein.

206. This Count is brought against Defendants Wayne T. Smith and W. Larry Cash.

207. Messrs. Smith and Cash, by virtue of their positions as officers and directors of CHS, acted as controlling persons of Defendant CHS within the meaning of Section 20(a) of the Exchange Act. Messrs. Smith and Cash had the power to control or influence, and did control and influence, the particular acts of CHS giving rise to the violations of Sections 14(a) and 10(b) of the Exchange Act and SEC Rules 14a-9 and 10b-5. As controlling persons of CHS, Messrs. Smith and Cash are liable pursuant to Section 20(a) of the Exchange Act.

208. Defendants Smith and Cash are jointly and severally liable under Section 20(a) of the Exchange Act to the same extent as Defendant CHS for the primary violations of Sections 14(a) and 10(b) of the Exchange Act and SEC Rules 14a-9 and 10b-5, as set forth herein.

REQUEST FOR RELIEF

WHEREFOR, Tenet prays for a judgment against Defendants as follows:

a) declaring that Defendants' proxy solicitations and statements related thereto violate Section 14(a) of the Exchange Act and SEC Rule 14a-9;

b) declaring that Defendants' public statements violate Section 10(b) of the Exchange Act and SEC Rule 10b-5;

c) ordering CHS to correct by public means its material misstatements and omissions in its proxy solicitations and statements related thereto, and to file with the SEC accurate disclosures required by

Section 14(a) of the Exchange Act and SEC Rule 14a-9;

d) ordering CHS to make full, complete and accurate disclosure to Tenet and its shareholders, sufficiently in advance of the November 3, 2011 shareholder meeting to enable Tenet's shareholders to make informed decisions at that meeting;

e) enjoining Defendants from disseminating materially false and misleading proxy solicitations and from making any additional materially false and misleading statements or omissions;

f) awarding Tenet its costs and disbursements in connection with investigating Defendants' materially false and misleading proxy solicitations and statements related thereto;

g) awarding Tenet its costs and disbursements in this action, including reasonable attorneys' and experts' fees;

h) declaring Defendants Smith and Cash liable under Section 20(a) of the Exchange Act; and

i) granting Tenet such other and further relief as this Court may deem just and proper.

Dated: Dallas, Texas
April 11, 2011

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APPENDIX J

UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF TENNESSEE

NORFOLK COUNTY RETIREMENT SYSTEM, individually and on behalf of all others similarly situated, *Plaintiff*, v. COMMUNITY HEALTH SYSTEMS, INC., WAYNE T. SMITH and W. LARRY CASH, *Defendants*.	CONSOLIDATED CIVIL ACTION NO.: 11-cv-0433 JUDGE JOHN T. NIXON MAG. JUDGE E. CLIFTON KNOWLES JURY TRIAL DEMANDED
THIS DOCUMENT RELATES TO ALL ACTIONS	

[REDACTED] CONSOLIDATED CLASS ACTION COMPLAINT FOR VIOLATIONS OF FEDERAL SECURITIES LAWS

TABLE OF CONTENTS

PAGE

NATURE OF THE ACTION 1

JURISDICTION AND VENUE 12

PARTIES 13

ADDITIONAL SUBSTANTIVE ALLEGATIONS 18

A. CHS Developed a Corporate Culture Centered Around Boosting Admissions 18

B. CHS Ignored Patient Needs and Medicare Rules In Order to Boost Its Revenues 22

C. CHS's Undisclosed Practices Increased Revenue Through Improper Patient Admissions 26

1. CHS Used the Blue Book to Justify Systematic Admissions that Were Not Medically Necessary in Order to Boost Medicare Revenues 26

a. Tenet's Complaint Contained Substantially Similar Allegations Regarding CHS's Adoption and Implementation of the Blue Book and the Resulting Increased Admissions at CHS 32

i. Chest Pain 32

ii. Syncope or Pre-Syncope 37

iii. Community Acquired Pneumonia. 39

iv. Cellulitis. 40

b. The *Qui Tam* Action Contained Substantially Similar Allegations 42

2. CHS and its Senior Leadership Rigged Pro-MED To Drive Improper Inpatient Admissions From Its ED 43

3. CHS's Quotas and Financial Incentives, Along with its Enforcement Mechanisms, Ensured that CHS Personnel Met Admissions Targets 48

D. CHS's Admission Rates Diverged Dramatically From its Competitors 52

E. Lead Plaintiff's Statistical Evidence Shows That CHS's Strategies Were Extremely Effective and Resulted in Admission and Observation Rates That Diverged Dramatically From its Competitors 54

1. CHS's Observation Rate vs. Industry 54

2. CHS's Observation Rate vs. Average of High Quality Systems 55

3. CHS's Observation Rate vs. Rural Hospitals in Same Geographic Area 56

4. Disproportionate Share of CHS's Admissions are "One-Day Stays" 57

F. CHS's Medicare Manipulation Enhanced the Company's Growth by Acquisition Strategy 59

G. CHS's Improper Admissions Practices Significantly Inflated its Revenues. 60

H. CHS's Admission Rates Steadily Decline After It Discontinues Use of The Blue Book 60

I. Additional Facts Supporting a Strong Inference of Scienter 61

J. Defendants' Additional Material Misstatements And Omissions During The Class Period 70

Second Quarter 2006 70

Third Quarter 2006 73

Fourth Quarter and Full Year 2006. 74

First Quarter 2007 79

Second Quarter 2007 80

Third Quarter 2007 82

Fourth Quarter and Full Year 2007 84

First Quarter 2008 86

Second Quarter 2008 90

Third Quarter 2008 93

Fourth Quarter and Full Year 2008 95

First Quarter 2009..... 97

Second Quarter 2009 99

Third Quarter 2009 101

Fourth Quarter and Full Year 2009 102

First Quarter 2010..... 105

Second Quarter 2010 107

Third Quarter 20l0 108

Fourth Quarter and Full Year 2010 110

CHS's Attempt to Takeover Tenet..... 110

CLASS ACTION ALLEGATIONS..... 118

LOSS CAUSATION/ECONOMIC LOSS..... 120

NO SAFE HARBOR 121

CLAIMS FOR RELIEF 122

COUNT I

Against All Defendants for Violations of Section l0(b) and Rule l0b-5 Promulgated Thereunder. 122

COUNT II

Against the Individual Defendants for Violations of Section 20(a) of the Exchange Act. 123

PRAYER FOR RELIEF 124

DEMAND FOR TRIAL BY JURY 125

1. Lead Plaintiff, the New York City Pension Funds, as defined herein at ¶¶38-43, for their Consolidated Class Action Complaint (the "Complaint"), alleges the following upon personal knowledge as to themselves and their own acts, and upon information and belief based upon the investigation made by and through their attorneys as to other matters. Lead Plaintiff's investigation included, *inter alia*, a review and analysis of: (a) public documents pertaining to Community Health Systems, Inc. ("CHS" or the "Company") and its senior executive officers and directors including filings with the United States Securities and Exchange Commission (the "SEC"); (b) analyst reports concerning the Company; (c) transcripts of CHS's earnings, conference calls and investor presentations; (d) internal CHS documents produced by defendants pursuant to this Court's order, dated March 23, 2012 (Docket No. 67); (e) facts provided by confidential witnesses who are former employees of CHS; (f) statistical analyses performed using the Center for Medicare and Medicaid Services ("CMS") database; and (g) the proceedings in several related actions, including *Tenet Healthcare Corporation v. Community Health Systems, Inc., et al.*, 11-cv-00732-M (N.D. Tex.) (the "*Tenet Litigation*") and *United States ex rel. and Reuille vs. Community Health Sys. Professional Serv. Corp. and Lutheran Musculoskeletal Ctr., LLC d/b/a Lutheran Hospital*, Case No. 1:09-CV-0007 (N.D. Ind.) (the "*Qui Tam* Action").

NATURE OF THE ACTION

2. This is a securities class action brought on behalf of all persons or entities who purchased or

otherwise acquired the publicly traded securities of CHS from July 27, 2006 through April 8, 2011 (the "Class Period"), and seeks recovery of monetary damages from CHS and its senior officers for violations of Sections l0(b) and 20(a) of the Securities Exchange Act of 1934 (the "Exchange Act"), 15 U.S.C. §§ 78j(b) and 78t(a), and SEC Rule l0b-5.

3. This class action was precipitated by disclosures made in April 2011 by Tenet Healthcare Corporation ("Tenet") in fending off CHS's attempted hostile takeover of Tenet. Tenet, a competitor in the same medical services field as CHS, revealed various practices that CHS had employed for many years to improperly drive up patient admissions at its hospitals and to inflate Medicare reimbursements. When Tenet exposed these undisclosed practices, which subjected CHS to potential financial and legal liabilities to government regulators, private insurance companies and patients, CHS stock immediately plummeted by nearly 36% in one day. This dramatic decline reflected the materiality of the information and the market's appreciation that, whether or not the government investigations lead to an indictment, the Company's aggressive, non-industry admission practices would have to be discontinued, and investors could no longer count on the high growth rates and Medicare reimbursements that CHS had consistently reported over the years.

4. Lead Plaintiff, through its counsel, performed an independent investigation of the veracity of Tenet's claims, including analyzing an enormous Medicare data set and interviewing numerous former CHS employees who served in a variety of positions throughout the Company, whose

statements corroborate the substantive facts alleged in the *Tenet Litigation*. Similarly, Tenet made clear that much of the factual allegations contained in its complaint was confirmed by CHS's former "doctors, nurses, and hospital executives".

5. As detailed below, the Company has for years engaged in improper practices designed to systematically drive up patient admissions at CHS hospitals, rather than observing those patients, for financial rather than clinical reasons. These improper practices included the use of a unique, non-industry set of aggressive admission justifications known as the "Blue Book;" programming the "Pro-MED" software system used in the Emergency Department ("ED" or "ER") of CHS hospitals to prompt patient admissions based upon testing and treatments that were not medically necessary; and implementing incentive programs and quotas to persuade CHS medical personnel to adhere to CHS's admissions strategies.

6. These strategies, among others, enabled CHS to boost the volume of inpatient admissions, which generated more Medicare revenues for CHS than if the patients were placed in observation status or discharged. As a result, Defendants' public statements touting, *inter alia*, CHS's admission rates and financial results, the "consistent execution: of [CHS's] centralized and standardized operating strategies," and "synergies" achieved at newly acquired hospitals, were materially false and misleading.

7. Defendants misrepresented and failed to disclose numerous material facts during the Class

Period concerning CHS's core business practices, including that:

- CHS was using a set of admissions criteria, known as the Blue Book that was inconsistent with industry standards;
- These internally created and liberal admissions criteria, along with the Pro-MED System that was rigged to raise patient acuity levels, and CHS's quota, incentive and enforcement mechanisms, have caused CHS hospitals to systematically admit ED patients to the hospital whose medical condition did not require inpatient treatment, resulting in higher admission rates and Medicare reimbursements than CHS would have recorded had it admitted patients according to medical need, as required under Medicare rules and regulations;
- CHS has failed to accurately disclose the basis for increased admissions at its acquired hospitals - including how the number of one-day inpatient stays rose dramatically at CHS's acquired hospitals;
- CHS's reported revenues, profits and earnings growth were artificially inflated by virtue of its undisclosed deception.

8. Numerous former employees have provided details about CHS's patient admissions scheme and, to the extent that Medicare and Medicare coverage was implicated, the overbilling of Medicare. For example, Confidential Witness #1 ("CW #1") was a Charge Master Manager from 2004 until 2009 in the

Revenue Management Department of CHS. CW #1 worked at CHS headquarters and was responsible for the programming and implementation of its clinical software system, known as Pro-MED, throughout the entire Company, as well as training ER staff consistent with CHS's admissions coding policies. Pro-MED was used by CHS to record a patient's diagnosis, generate diagnostic tests, and "prompt" patients for admission. As a Charge Master Manager, CW #1 was also responsible for training employees about CHS's policies and procedures for charging Medicare and other issuers for the services rendered through the ER.

9. According to CW #1, she was instructed by her managers, throughout her employment, but particularly beginning in 2006, to "adjust" the Pro-MED software so that it would "generate more admissions rather than observation orders." CW #1 was also instructed to "adjust" CHS's Charge Description Masters for all of CHS's hospitals so that "Pro-MED would boost the acuity of ER patients" to higher levels virtually assuring that the patient would be admitted rather than placed in observation status. According to CW #1, these instructions to alter Pro-MED amounted to "over-coding – making something out of nothing." CW #1 argued with her supervisor, Craig Plattner ("Plattner"), about these improper admission practices that were "driving admissions" because CHS was training its staff to "deliver a higher level of service than the patients needed." CW #1 did not think it was right and believed it was insurance fraud. CW#l also believes that as much as 30% of CHS's ER admissions were inappropriate.

10. CW #1 also revealed that CHS's scheme to boost admissions was orchestrated at the highest levels of CHS. CW #1 reported to Plattner, who was the Director of Revenue Management. In her position at headquarters, CW #1 had direct access to CHS's senior leadership, including Larry M. Carlton ("Carlton"), CHS's Senior Vice President of Revenue Management and CHS's CFO, Defendant Larry Cash. Cash, Carlton and Plattner were members of a special revenue management committee at CHS (the "Revenue Committee"), tasked with creating CHS's admission policies aimed at boosting CHS's ER patient admissions. The Revenue Committee decided to increase admissions, especially beginning in or about 2006, by altering Pro-MED to boost the acuity levels of its ER patients and by hiring a half dozen "clinical documentation specialists" to teach ER doctors and nurses how to write their orders in patients' charts to justify their admissions in the event of an audit.

11. CW #1 specifically recalled Defendant Cash asking her questions at Revenue Committee meetings about boosting the "census" (*i.e.*, the occupancy rate) at specific CHS hospitals that he wanted to target. Defendant Cash further asked CW #1 if "we can bump our level 2s to level 4s" (referring to the Pro-MED acuity levels), in order to virtually guarantee that more patients would be admitted. CW #1 also understands that the CEO Wayne Smith was well aware of these improper admission policies because everything Cash and the Revenue Committee did, needed "Wayne's approval."

12. CHS's senior executives were cognizant of the fact that their scheme to improperly boost

admissions could not succeed unless it was concealed. CW #1 was instructed to make sure the changes she made to Pro-MED were done in such a way as to "survive an audit." In addition, CW #1 also stated that the way in which CHS trained its staff to write orders were all geared toward "escaping detection" and "surviving an [internal or external] audit".

13. CHS's scheme centered on driving up inpatient admissions because, according to CHS and as alleged by Tenet, Medicare and managed care companies pay more for inpatient treatment than for outpatient observation treatment, which involves a shorter hospital stay and typically less testing and monitoring. By Tenet's estimation, CHS receives on average $3,500 more from Medicare for a given inpatient admission than for outpatient observation status.

14. CHS employed three co-existing strategies to systemically boost ER admissions. First, starting in or about 2000, CHS developed and implemented its own set of liberal "Admission Justifications" and codified them in a small booklet known as the "Blue Book." The Blue Book contained a set of aggressive admissions criteria that lacked a well-accepted evidentiary basis. No other hospital in the U.S. used the Blue Book. Rather, over 75% of U.S. hospitals utilized one of the following two sets of independent, third-party admissions criteria: InterQual or Milliman, which are based upon objective, clinical results. InterQual was developed by an independent panel of 1,100 physicians and medical providers, contain over 16,000 references to medical sources, and are used by 3,700 hospitals across the country,

over 300 health plans and CMS. Similarly, the Milliman Care Guidelines, which have more than 15,000 medical references and are used by over 1,000 hospitals, were developed by an experienced team of physicians and reviewed by approximately 100 independent doctors.

15. However, as Tenet explained, the Blue Book was structured around aggressive "Admission Justification[s]." It was not an objective set of criteria for determining appropriate patient treatment whether in observation or admission. Rather, its purpose was to provide a mechanism for CHS management to justify to its medical staff criteria for the admissions of patients who otherwise could have been observed and released. In that way, CHS hospital could maximize admissions and charge Medicare correspondingly higher amounts. InterQual, on the other hand, rejects factors similar to these aggressive Blue Book Admission Justifications as a basis for admitting a patient to the hospital. Even though the Blue Book was copyrighted in 2000 at the U.S. copyright office, CHS never disclosed to public investors its use of the Blue Book's unique justifications to boost admissions.

16. Former CHS employees confirm that CHS mandated that the Blue Book be used in its hospitals and regularly trained its hospital personnel on how to use it in order to boost admissions. For example, Confidential Witness #2 ("CW #2") worked as Regional Business Development Manager for the Northeast Region of CHS from January 2006 through January 2007. CW #2 was responsible for developing new business and tracking patients for 12 of CHS's hospital-based hospice and homecare

programs and reported directly to the director of business development for CHS's homecare operations at CHS's headquarters. In that capacity, CW #2 frequently met and worked with CHS's case managers, who are responsible for reviewing the propriety of patient admissions. These hospital case managers informed CW #2 that CHS had one goal - if a patient came into the ER, "*the goal was to get them admitted using the Blue Book. The goal was not to do 23 hours of observation. It was to admit (the patient) and start collecting the money.*"

17. CHS's second strategy was to program the Pro-MED software system to generate medically unnecessary tests and procedures so as to assure that a patient would be admitted, rather than just observed at CHS. Pro-MED was used to track patients as soon as they entered the ED. Pro-MED was also used by CHS to order or "flag" tests and procedures, based on the patient's presenting injury, and assign an acuity level (1 through 5) to each of CHS's ED patients. If a patient's acuity level reached a high level, Pro-MED) would prompt the admission of the patient. As explained above through the information provided by CW #1, CHS intentionally programmed Pro-MED to initiate tests and procedures for patients in the ED, irrespective of whether the test or procedure was necessary, for the purpose of prompting additional admissions of patients. Through a battery of unnecessary tests prompted by Pro-MED and by training ER staff to use certain verbiage, ER rooms would boost the acuity levels of ER patients so that they would qualify for admissions. According to CW #1, CHS did this for one reason: "they just got greedy."

18. While Defendants Smith and Cash made public statements touting Pro-MED's success in increasing ER admissions rates, particularly at CHS's newly-acquired hospitals, Defendants failed to disclose that success had been largely achieved by programming Pro-MED to raise patient acuity levels by prompting medically unnecessary testing and thereby increase the volume of patient admissions.

19. CHS's third strategy involved incentivizing its staff to meet pre-set "quotas" for its admissions rate and by paying them bonuses or giving employees prizes. As detailed herein, former CHS employees acknowledged that regional managers and hospital supervisors received bonuses based on the percentage of Medicare patients admitted and how much revenue they brought in. CW #2 succinctly put the matter: "If you didn't produce [admissions], you were done."

20. Former CHS employees also disclosed that CHS had an admissions quota. For example, Confidential Witness #3 ("CW #3") worked as an Emergency Room Director (from 2008 to 2011) at Haywood Park Community Hospital ("Haywood Park") and as an ICU nurse (from 2005 to 2008) at Regional Hospital of Jackson (from 2008 to 2011). CW #3 reported to Chief Nursing Officer, Steve Collins, and attended daily meetings with Haywood Park's CEO, Jeremy Gray. CW #3 was responsible for directing and coordinating all aspects of Haywood Park's ED and acted as a liaisons between the hospital's Administration and its medical staff. According to CW #3, CHS set a quota for admissions and required its ED admission rate to be 20%. CW#3 also revealed that CHS paid bonuses to its employees

based on the number of Medicare admissions they achieved.

21. CHS's undisclosed practices were highly successful in boosting its ED admission rates. As part of its investigation, Lead Plaintiff retained a world-renowned expert in health economics and finance to perform numerous statistical analyses of CHS's Medicare data. This healthcare consultant has worked for 25 years as a consultant for RAND, the largest funded health research service in the world. He has previously been retained by the U.S. Department of Health and Human Services, served as an expert witness for the Federal Trade Commission, and testified before Congress on hospital healthcare issues. The results of Lead Plaintiff's healthcare expert's Medicare data analysis support one inescapable conclusion: patients were much more likely to be admitted at a CHS hospital than at other hospitals for higher paying treatment, rather than being observed and discharged. Indeed, Lead Plaintiff's healthcare consultant found that over 93% of CHS's hospitals have observation rates below the national average. This means that a patient is far more likely to be treated in the higher-paying inpatient admission status, and far less likely to be treated in lower-paying observation status, if the patient visits a CHS hospital than if the patient visits a hospital operated by CHS's peers.

22. To explain, hospitals can treat in observation for 48 hours, indeed a full panoply of treatment options are available in observation, so a high rate of single-day stays bespeaks of an aggressive admissions policy. CHS admitted a significant number of patients who should have been

treated in observation, resulting in the percentage of CHS's admitted patients who stayed in the hospital a single day being consistently higher than the industry average during the Class Period. Indeed, Lead Plaintiff's healthcare consultant found that nearly 70% of CHS hospitals admitted ER patients for one-day stays at a rate substantially above the national average.

23. The impact of CHS's scheme is illustrated through CHS's acquisition of Triad Hospitals, Inc. ("Triad") in July 2007, which added 50 hospitals to CHS. As revealed in the *Tenet Litigation*, in the year following the acquisition, CHS implemented its ED practices in the newly acquired Triad hospitals, imposing the Blue Book over - the more widely accepted - InterQual admission criteria which Triad had been using. Triad's use of observation status for patients at the former Triad hospitals decreased by more than 50%. This shifted would-be observed patients to inpatient admitted status to generate substantial additional revenue for CHS. Unsurprisingly, Triad's percentage of "one-day stay" admissions, which Medicare auditors consider to be potentially indicative of improper admissions, increased by 33% in the year following the CHS acquisition, with even higher increases for patients with common conditions such as chest pain, syncope, and GI-bleed.

24. While attributing its success to "synergies" and "greater operating efficiencies" achieved in the Triad acquisition, CHS failed to disclose that the apparent success was driven in large part by employing CHS's suspect admission strategies at Triad to systematically boost admissions.

25. On April 11, 2011, as part of its effort to fend off a hostile takeover by CHS, Tenet filed a report on SEC Form 8-K that disclosed the results of its own investigation into CHS's improper admission practices. On the same day, Tenet filed a complaint in the United States District Court for the Northern District of Texas, in which it identified several false and/or misleading statements in CHS's proxy disclosures about the basis of its admission statistics, revenues and potential synergies to be achieved in the event Tenet was acquired by CHS.

26. Tenet also alleged that CHS's improper practices resulted in CHS receiving additional revenues from Medicare alone of up to $306 million during 2006-2009, and up to $345 million during 2003-2009.

27. The market's response to these revelations was immediate and dramatic - CHS common stock plunged nearly 36 percent, or $14.41, from a close of $40.30 on Friday, April 8, 2011 to close at $25.89 on Monday, April 11, 2011.

28. In response to Tenet's allegations, CHS acknowledged that it had recently decided to move from the Blue Book to InterQual, but falsely represented that (1) the Blue Book and InterQual had similar admission criteria, and (2) the Blue Book was "based on current clinical practice." Moreover, although Smith and Cash both made public statements during the Class Period touting Pro-MED's ability to increase ED admissions, particularly at newly-acquired hospitals, Defendants, in an obvious attempt to buoy CHS's market price,

falsely denied that Pro-MED impacted ED admission rates.

29. Moreover, after Tenet filed its complaint, CHS belatedly disclosed that it currently was the target of numerous government investigations, including an investigation by the U.S. Department of Health and Human Services, Office of the Inspector General (the "OIG"), and various United States Attorneys' offices, as well as the State Attorney General of Texas, that related to its ED admissions practices and Medicare billing.

30. CHS also belatedly revealed that it had received a letter in the Fall of 2010 from a shareholder group, CtW Investment Group, identifying and requesting that they halt the same improper and unsustainable admissions practices at CHS hospitals as alleged in this action.

31. CHS also belatedly disclosed, after Tenet's allegations were made public, that these same allegations of improper admissions practices were raised in the *Qui Tam* Action filed on January 7, 2009 against CHS and/or its subsidiaries. The *Qui Tam* Action was unsealed on December 27, 2010, but CHS chose not to disclose these facts to investors until mid-April 2011.

32. Defendants were also aware of, but did not disclose, other government investigations and/or audits regarding CHS's billing practices. Lead Plaintiff obtained through information provided by Confidential Witness #4 ("CW #4"), who was the former Administrative Director of Payson Regional Medical Center, a CHS-operated hospital in Payson, Arizona ("Payson"), from 2002 to 2007, who reported

to Payson's CEO, Chris Wolf, who in tum reported to Bill Hussey, President of Division IV Operations. CW #4 revealed that an Arizona state agency, which he believed to be the Arizona Department of Health, audited CHS's admission practices and operations between 2005-2007 and found that "it had a significantly low rate of observation" and higher than normal number of short patient stays in the hospital, admissions of just over 24 hours.

33. CHS's improper practices and strategies have ultimately proven to be unsustainable. As CHS reduced and then discontinued the use of the Blue Book – its rate of same-store hospital admissions steadily declined.[1] Moreover, notwithstanding CHS's repeated denials of Tenet's allegations and other efforts described herein to influence the market, CHS's stock price has remained at its pre-inflation levels.

JURISDICTION AND VENUE

34. The claims asserted herein arise under Sections 10(b) and 20(a) of the Exchange Act, 15 U.S.C. §§ 78j(b) and 78t(a), and SEC Rule l0b-5 promulgated thereunder.

35. This Court has jurisdiction over the subject matter of this action pursuant to 28 U.S.C. §§ 1331 and 1337, and Section 27 of the Exchange Act, 15 U.S.C. § 78aa.

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[1] Same-store admissions is an industry term used by CHS in its public filings to measure year-to-year changes in certain metrics, such as inpatient admissions, for hospitals in CHS's portfolio for at least one year.

36. Venue is proper in this District pursuant to Section 27 of the Exchange Act, 15 U.S.C. § 78aa, and 28 U.S.C. § 1391(b).

37. In connection with the challenged conduct, defendants, directly or indirectly, used the means and instrumentalities of interstate commerce, including, but not limited to, the U.S. mails, interstate telephone communications, and the facilities of the national securities markets.

PARTIES

38. Lead Plaintiff the New York City Employees' Retirement System ("NYCERS"), the Teachers' Retirement System of the City of New York ("NYCTRS"), the New York City Fire Department Pension Fund ("FIRE"), the New York City Police Pension Fund ("POLICE"), and the Teachers' Retirement System of the City of New York Variable Annuity Program ("NYCTRS Variable A") (collectively, the "Funds" or "Lead Plaintiff '), are part of one of the largest pension systems in the nation. As of March 31, 2012, Lead Plaintiff collectively had more than $120.8 billion in assets, and had approximately 623,000 active and retired members. On December 28, 2011, this Court duly appointed the Funds as Lead Plaintiff in this action.

39. NYCERS, established under Section 12-102 of the Administrative Code of the City of New York, provides pension benefits to all New York City employees who are not eligible to participate in separate Fire Department, Police Department, Teachers, or Board of Education pension funds.

40. NYCTRS maintains two separate retirement programs, the Qualified Pension Plan ("QPP") and the Tax-Deferred Annuity Program ("TDA"). The QPP, established pursuant to Section 13-502 of the Administrative Code of the City of New York, provides pension benefits to those with regular appointments to the pedagogical staff of the New York City Board of Education. The TDA, also known as NYCTRS Variable A, was established pursuant to Internal Revenue Code Section 403(b), to provide a means of deferring income tax payments on voluntary tax-deferred contributions.

41. FIRE, established pursuant to Section 13-301 of the Administrative Code of the City of New York, provides pension benefits for full-time uniformed employees of the New York City Fire Department.

42. POLICE, created pursuant to New York Local Law 2 of 1940, provides pension benefits for full-time uniformed employees of the New York City Police Department.

43. Each of the Funds purchased or acquired CHS common stock during the Class Period and suffered damages as a result of the federal securities law violations alleged herein. During the Class Period, the NYC Funds purchased a total of approximately 762,966 shares of CHS common stock on the open market, as set forth in their certifications previously filed in connection with the motion for appointment as the Lead Plaintiff. *See* Docket No. 34.

44. Defendant CHS is a Delaware corporation headquartered at 4000 Meridian Boulevard in

Franklin, Tennessee. CHS's common stock is listed on the New York Stock Exchange (the "NYSE") under the ticker symbol "CYH."

45. CHS is the largest publicly traded hospital operator in the United States. The Company currently operates and leases more than 131 acute-care hospitals in non-urban markets in 29 states. For 2011, CHS reported $13.6 billion in net revenue. Since approximately 27 percent of CHS's net operating revenue is derived from Medicare reimbursement payments, the Company readily acknowledges that its success depends in large measure upon its ability to comply with the Medicare Program.

46. Defendant Wayne T. Smith ("Smith") has served as CHS's Chairman of the Board of Directors (the "Board"), President and Chief Executive Officer ("CEO") since 2001. Smith also served as CHS's CEO, President and as a CHS director from 1997 to 2001. In addition to CHS, Smith has been an executive and/or director of several public companies operating in the healthcare industry, including Humana, Inc. ("Humana"), the Nashville Healthcare Council and the Federation of American Hospitals.

47. As an experienced industry professional, Smith was aware that CHS was required to comply with Medicare reimbursement standards and other federal and state laws. Nonetheless, he approved of improper inpatient admission practices at CHS hospitals for the purpose of obtaining higher and unwarranted payments from Medicare and other third-party payers; closely monitored the results of the centralized and systemic strategy employed at CHS hospitals; and made materially false and

misleading public statements about CHS's business practices and financial performance during the Class Period.

48. While in possession of material, non-public information concerning CHS's true business operations, Defendant Smith sold 500,000 shares of his Community Health stock for $16,770,301 in proceeds as follows:

Insider Last Name	Transaction Date	Shares	Price	Proceeds
SMITH	5/20/2009	250,000	$26.07	$6,518,650
	5/13/2010	243,093	$41.02	$9,971,918
	5/13/2010	6,907	$40.50	$279,733
		500,000		$16,770,301

49. Defendant W. Larry Cash ("Cash") has been CHS's Chief Financial Officer ("CFO") and Executive Vice President since 1997 and a Director since 2001. In addition to CHS, Cash has been an executive and/or director of several public companies operating in the healthcare industry, including Columbia/HCA Healthcare Corporation, Humana and Cross Country Healthcare, Inc. As an experienced industry professional, Cash was aware of the standards for Medicare reimbursement as well as other applicable federal and state laws. Nonetheless, he approved of and promoted improper inpatient admissions practices at CHS hospitals for the purpose of obtaining higher and unwarranted payments from Medicare and other third-party payers; closely monitored the results of this systematic strategy employed at CHS hospitals; and made materially false and misleading public statements about CHS's business practices and financial performance.

50. Strongly indicative of his scienter, Defendant Cash sold 480,000 shares of his CHS

stock netting $17,069,760 in proceeds. The following stock sales occurred while Cash was in possession of material, non-public information concerning CHS's true business practices that improperly boosted ER admissions:

Insider Last Name	Transaction Date	Shares	Price	Proceeds
CASH	8/4/2009	240,000	$30.79	$7,388,400
	4/26/2010	240,000	$30.34	$9,681,360
		480,000		$17,069,760

51. These stock sales were completed while Cash was in possession of material information about CHS's improper revenue generation, which was not disclosed to CHS's investors, are strong indicia of scienter.

52. Defendants Smith and Cash are collectively referred to herein as the "Individual Defendants," and together with CHS, are referred to as the "Defendants."

53. During the Class Period, the Individual Defendants, as senior executive officers and/or directors of CHS, were privy to confidential and proprietary information concerning CHS, its operations, finances, financial condition, and present and future business prospects. The Individual Defendants also had access to material adverse, non-public information concerning CHS, as discussed in detail below. Because of their positions with CHS, the Individual Defendants had access to non-public information about the Company's business, finances, and future business prospects through access to internal corporate documents, reports, conversations, and their connections with other corporate officers and employees, and their attendance at management and/or board of directors meetings and committees.

Because of their possession of such information, the Individual Defendants knew of, and/or recklessly disregarded, the Company's misrepresentations during the Class Period.

54. The Individual Defendants are liable as direct participants in the wrongs complained of herein. In addition, the Individual Defendants, by reason of their status as senior executive officers and/or directors, were "controlling persons" within the meaning of Section 20(a) of the Exchange Act, and had the power and influence to cause the Company to engage in the unlawful conduct complained of herein. Because of their positions of control, the Individual Defendants were able to, and did, directly or indirectly, control the conduct of CHS's business.

55. The Individual Defendants, because of their positions with the Company, controlled and/or possessed the authority to control the contents of CHS's reports, press releases, and presentations to securities analysts and, through them, to the investing public. The Individual Defendants were provided with and approved the Company's reports and press releases alleged herein to be misleading, and had the ability and opportunity to prevent their issuance or cause them to be corrected. Many statements in public company releases were specifically made by the Individual Defendants. Thus, the Individual Defendants had the opportunity to commit the fraudulent acts alleged herein.

56. As senior executive officers and/or directors and as controlling persons of a publicly-traded company whose common stock is registered with the SEC, traded on the NYSE, and governed by the

federal securities laws, the Individual Defendants had a duty to promptly disseminate accurate and truthful information with respect to CHS's financial condition and performance, growth, operations, financial statements, business, products, markets, management, earnings, and present and future business prospects, and to correct any previously issued statements that had become materially misleading or untrue so that the market price of CHS's securities would be based upon truthful and accurate information. The Individual Defendants' misrepresentations and omissions during the Class Period violated these specific requirements and obligations.

ADDITIONAL SUBSTANTIVE ALLEGATIONS

I. CHS Developed a Corporate Culture Centered Around Boosting Admissions

57. Throughout the Class Period, Defendants routinely made materially false and misleading statements to CHS investors concerning its operations, financial performance and admission rates in failing to disclose that those successful results were driven in large part by a corporate culture and practice at CHS that improperly boosted admissions in order to collect more revenue from Medicare and other third-party payers such as insurance companies. As Defendant Cash was quick to highlight, "almost 60% of [CHS's] admissions, legacy CHS came through the emergency room" (March 4, 2008 Raymond James Institutional Investors Conference). As a result, CHS's ability to drive up ER admissions rates in existing and newly

acquired hospital was critical to the Company's financial performance.

58. To accomplish this apparent growth, CHS developed aggressive admissions criteria, codified in a booklet known as the Blue Book. CHS hospitals were required to adopt the Blue Book, and the Company held training conferences for its medical and administrative staff on how to use Blue Book to justify admissions. In addition, CHS utilized Pro-MED, a software program that guided CHS's medical professional's diagnostic and clinical determinations, in each hospital ED. Along with the Blue Book, Pro-MED was programmed, at the direction of senior CHS managers and executives, to increase the likelihood that a patient would be admitted at CHS rather than observed.

59. As noted above, CHS's scheme was orchestrated from the Company's headquarters where the Revenue Committee was formed to, *inter alia*, implement financial policies and track CHS's financial metrics, including hospital admissions. According to CW #1, whose direct supervisor (Plattner) was a member of the Revenue Committee, the Revenue Committee met weekly on the third floor of CHS headquarters in Franklin, Tennessee. From that location the Revenue Committee was able to track the admissions of every CHS hospital on a daily basis.

60. As explained by CW #1, the members of the Revenue Committee included some of CHS's senior executives, including Defendant Cash, Michael Miserocchi (the Vice President of Clinical Services who reported directly to Defendant Wayne Smith), Larry Carlton (Senior Vice President of Revenue

Management), Margaret Redmon (Senior Director of Revenue Management), Craig Plattner (Director of Revenue Management) and Carol Hendry (Vice President of Compliance).

61. CW #1 reported to Craig Plattner who, among the other members of the Revenue Committee, monitored CHS's "census" through CHS Health Management Systems and its data warehouse, which recorded admissions, observation status, revenues, and other data on a "daily basis."

62. CW #1 explained that Defendant Larry Cash and Larry Carlton "ran everything [the Revenue Committee] did past Wayne Smith." Further, CW #1 stated that Defendant Cash and Carlton "could not make decisions without Wayne's approval." Thus, the Revenue Committee reported directly to Wayne Smith.

63. Another former employee interviewed by Lead Plaintiff, Confidential Witness #5 ("CW #5") also worked at CHS's headquarters as a Senior Financial Analyst for the Financial Reporting Information Team from 2008-2010 and reported to Scott Gardner (a former Director of Application Services). CW #5 participated in weekly committee meetings at CHS headquarters in which all of the controllers for each of CHS's five operational divisions participated and his group worked to determine how admissions were processed for billing and financial reporting purposes for the entire Company. CW#5 stated that the committee standardized the rules for counting admissions and other hospital services for all CHS hospitals and the newly acquired Triad hospitals. CW #5 explained that the committee referred to the Blue Book and

applied sections of it to the uniform standards the committee was establishing. CW #5 stated that it was his group's task to implement any of changes the committee made to CHS's company-wide healthcare management system.

64. In order to centrally organize its hospitals, CHS devided CHS's geographically diverse hospitals into five geographical "Divisions" as follows:[2]

REDACTED

65. As indicated in the documents produced by CHS, each Division is headed by a President, REDACTED Each Division reported REDACTED These Presentations, a few of which CHS produced to Lead Plaintiff, report REDACTED

66. The admission statistics of each Division and the hospital within each Division were closely monitored by CHS. For example, REDACTED

67. Moreover, the Board presentation submitted by Division III's President, Gary Newsome ("Newsome"), REDACTED

68. REDACTED

69. Moreover, according to the minutes of the Board meeting held on REDACTED the Board Directors reviewed REDACTED presentation prepared by REDACTED

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[2] According to CHS's internal records, the states encompassed within each Division have, from time to time, been reorganized between Divisions.

J. CHS Ignored Patient Needs and Medicare Rules In Order to Boost Its Revenues

70. CHS's failed to disclose that the Company had adopted a policy that violated a fundamental principle of medical care: to treat patients based upon their clinical needs, not to boost the hospital's bottom line, and to seek reimbursement for only those services that are reasonable and medically necessary to serve the patient.

71. As initially explained by Tenet, when a patient suffering from a medical condition seeks treatment at a hospital's emergency department or is otherwise referred to the hospital, physicians have three choices with respect to forms of treatment: (1) admit the patient to the hospital on an inpatient basis; (2) admit the patient on an outpatient observation basis for care and monitoring that is expected to last less than 24 hours; or (3) not admit the patient, instead discharging the patient following treatment.

72. Tenet also described Medicare rules that govern patient treatment. The use of observation status to treat patients is widely recognized as an essential tool for improving clinical decision making and providing cost effective medical care. Under the Medicare Benefit Policy Manual:

> Observation care is a well-defined set of specific, clinically appropriate services, which include ongoing short term treatment, assessment, and reassessment before a decision can be made regarding whether patients will require further treatment as hospital inpatients or if they are able to be discharged from the hospital.

> Observation services are commonly ordered for patients who present to the emergency department and who then require a significant period of treatment or monitoring in order to make a decision concerning their admission or discharge.

Medicare Benefit Policy Manual, Chapter 6, Section 20.6A.

73. Tenet explained that admission on an outpatient observation basis is warranted for patients who present with certain types of medical conditions, citing Louis Graff, MD, *Principles of Observation Medicine*, *in* Observation Medicine (Louis Graff ed. 2010), *available at* http://www.acep.org/content.aspx?id=46142&terms=Observation%20Medicine. For example, outpatient observation care is appropriate for patients whose medical conditions require diagnostic evaluation because: (1) the balance between the probability and severity of disease warrants further evaluation; (2) the patient presents a condition that cannot be readily diagnosed without additional testing; or (3) the physician needs more time to evaluate the patient's symptoms to determine the most appropriate medical treatment.

74. Outpatient observation care is also appropriate for patients who require short-term treatment of emergency conditions. In addition, patients who require therapeutic procedures that do not necessitate inpatient admissions, but who nonetheless require some period of hospital care, are generally treated in observation.

75. One benefit of outpatient observation care is its cost effectiveness relative to inpatient treatment, because the former requires shorter hospital stays and, typically, less testing and monitoring. The decision of whether to treat a patient on an inpatient admission basis or outpatient observation basis has significant financial ramifications for hospitals. Hospitals receive a much larger reimbursement from Medicare for treatment of a patient on an inpatient admission basis than on an outpatient observation basis. Accordingly, hospitals may have a financial incentive to improperly steer patients into inpatient admissions, rather than treat patients appropriately on an outpatient observation basis, and must employ safeguards to ensure their billing practices are appropriate. According to the Medicare Payment Advisory Commission (MedPAC), the independent Congressional agency that advises the U.S. Congress on issues affecting the Medicare program, for some patients, the Medicare program reimburses hospitals nearly 1000% more (or approximately $7,000 more per patient) when the patient is admitted to the hospital as compared to treatment for the same patient in observation status.[3]

76. Tenet also explained that to temper this incentive, Medicare laws and guidelines prohibit hospitals from billing Medicare for treatment of a patient admitted to the hospital unless a physician, at the time the patient presents to the hospital,

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[3] Presentation, MedPAC, "Recent Growth in Hospital Observation Care" (Sept. 30, 2010), *available at* http://www.medpac.gov/transcripts/observation%20sept%202010.pdf.

determines that the severity of the patient's condition requires care that the physician expects to meet or exceed 24 hours, and that placing the patient in a less intensive setting would significantly and directly threaten the patient's safety or health. *See* Medicare Benefit Policy Manual, Ch. 1 § 10; Medicare Program Integrity Manual, Ch. 6 § 6.5.2. In particular, under federal law, Medicare reimburses hospitals only for treatment that is "reasonable and necessary for the diagnosis or treatment of illness or injury." 42 U.S.C. § 1395y(a)(l)(A). In addition, Medicare intermediaries who make Medicare payments are prohibited under federal law from using Medicare funds to pay for services if those services were not "medically necessary, reasonable, and appropriate for the diagnosis and condition of the beneficiary." Medicare Program Integrity Manual, Ch. 6 § 6.5.2. In this regard, "[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." *Id.* In sum, federal law and applicable Medicare guidelines establish that, absent a medical need to treat the patient on an inpatient basis, Medicare is not responsible for payment of inpatient treatment.

77. Moreover, on information and belief, the use of outpatient observation, instead of inpatient admission, is appropriate when the need for inpatient admission cannot be medically determined and when additional time is needed to evaluate the patient or when the physician believes the patient will respond rapidly to treatment. Medicare coverage for outpatient observation is limited to a 48

hour period unless the fiscal intermediary grants an exception.

78. Tenet alleged that CHS contravened these Medicare provisions by utilizing the Blue Book's inappropriate inpatient admissions criteria. The purpose of the Blue Book was to provide a basis for CHS management to justify to its medical staff criteria for the admission of patients who otherwise could have been observed and released.

79. Defendants were experienced in providing billing to Medicare patients and knew the prohibitions at all relevant times. Defendants knew (i) the risks associated with establishing admissions criteria that improperly steered patients to costly inpatient admissions at CHS hospitals in order to collect unwarranted payments from Medicare and other sources; and (ii) that CHS could incur significant penalties and liability arising from federal and state investigations and proceedings, as well as private lawsuits and loss of goodwill, if they did not comply with applicable rules and regulations, other legal obligations, and widely accepted standards of clinical care.

80. As described herein, CHS's allegedly improper admissions practices are the subject of governmental investigations and private proceedings which the Company chose not to reveal until after these practices were exposed in the *Tenet Litigation*.

K. CHS's Undisclosed Practices Increased Revenue Through Improper Patient Admissions

1. CHS Used the Blue Book to Justify Systematic Admissions that Were Not Medically Necessary in Order to Boost Medicare Revenues

81. Under Medicare regulations, hospitals are required to maintain a set of admissions guidelines for determining whether a patient's condition is serious enough to warrant inpatient treatment. Such criteria are required to support treatment that is medically necessary. 42 C.F.R. § 482.30(c)-(d) ("The UR plan must provide for review for Medicare and Medicaid patients with respect to the medical necessity of -- (i) Admissions to the institution; (ii) The duration of stays . . . .")

82. As alleged herein, in contravention of these Medicare rules, CHS developed corporate-wide admissions criteria under the Blue Book that systematically encouraged medically unnecessary inpatient admissions at its hospitals. Numerous former employees have confirmed that CHS physicians and case managers were required to use the Blue Book for purposes of justifying the admission of a patient into a CHS facility. According to the terms of the Blue Book,[4] it contains admission

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[4] Consistent with the Court's scheduling order (Docket No. 67), CHS produced certain internal corporate records to Lead Plaintiff, including four versions of the "Blue Book" from the following years: 2006, 2007, 2009, and 2010. In addition, the NYC Funds obtained a 2003 version of the "Blue Book" through its investigation of the claims asserted against CHS herein. Each

criteria for the "most commonly encountered clinical scenarios presenting to a typical CHS facility." As described by Tenet, the Blue Book was designed to address patient conditions typically presented at CHS's emergency departments, such as chest pain, syncope, pneumonia, gastrointestinal bleeding, and atrial fibrillations.

83. Senior executives mandated that the Blue Book be used at CHS hospitals to the exclusion of other independent criteria. According to CW #4 CHS executives, including Carolyn Lipp ("Lipp"), a Senior Vice President of Quality and Utilization Management who, on information and belief, reported directly to Defendant Smith, required the use of the Blue Book and enforced its use through her regional managers. CW #4 also stated that Lipp held annual meetings at CHS's headquarters that focused on the Blue Book and stressed to CHS employees that CHS does not use "other admission[s] criteria." In this way, CHS made sure all of its hospitals were utilizing the Blue Book's liberal admissions criteria.

84. CHS encouraged its staff to make sure that physicians were using the Blue Book, because CHS knew it was designed to lead to increased admissions. Another former employee, CW #3, who was the Emergency Room Director at Haywood Park, stated that the Blue Book was "on the counter" at the ER and that she was encouraged by CHS management to inform doctors to use it. CW #3

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iteration of the Blue Book contained similar non-standard, aggressive admissions criteria. For illustrative purposes, this complaint refers to the 2009 version of the Blue Book.

explained that CHS used the Blue Book because CHS was "able to get more money" and that "[e]very admission was looked at again and again with the goal to keep the doors open." CW #3 added that the Blue Book; outlined "anything Medicare was going to pay for", including specific tests and procedures. CW #3 explained further that since Haywood was in a very poor, rural area that served many people without insurance, Medicare "was a sure payment" for CHS.

85. According to a CW #2, confirmed that CHS conducted on-site training on the Blue Book for "admitting and discharging patients, " which assured that hospitals were utilizing the Blue Book to its maximum effect.

86. Another former employee, Confidential Witness #6 ("CW #6"), worked as the Director of Case Management at Weatherford Regional Hospital in Weatherford ("Weatherford"), Texas from 2007-2008, and as the Director of Case Management at Lake Granby Medical Center in Granby, Texas ("Granby") from 2005-2007. CW #6 was responsible for training case managers and reviewing medical records daily to determine the appropriateness and medical necessity of admission at both Weatherford and Granby hospitals. At Granby, CW #6 was responsible for redesigning CHS's case management program in order to reduce patients length of stays. CW #6 was transferred to Weatherford, which was recently acquired by CHS, to implement CHS's model of case management. CW #6 reported to Chief Nursing Officer Steve Collins at Weatherford. CW #6 indicated that she used the Blue Book and her Case Management Manual, and received training, along

with others, for the Blue Book at CHS's headquarters in 2005. CW #6 stated that CHS hospital CEOs, CFOs, case managers and physicians attended the three-day Blue Book orientation, which she confirmed was led by Lipp, CHS's Senior Vice President of Quality and Utilization Management at CHS's headquarters.

87. Lead Plaintiff also received information from Confidential Witness #7 ("CW #7") who was a former Controller at Marion County Regional Hospital in South Carolina ("Marion") from March 1986 until September 2011. CHS acquired Marion in 2010 which is in CHS's Division I. CW #7 was responsible for maintaining Marion's books and finances and reported to Marion's business office manager, Elisa Smith. CW #7 stated that when Marion was purchased by CHS in 2010, Marion was told to "scrap InterQual and use the Blue Book." Consistent with the fact that the Blue Book was an unsustainable guideline, CW #7 stated that after Tenet filed its lawsuit, CHS reverted to using InterQual at Marion.

88. Confidential Witness #8 ("CW #8") worked at CHS as the Director of Emergency Services at CHS's Western Arizona Regional Medical Center ("Western"), from October 2004 to January 2006, and reported to JoAnn Kimball, CHS's Chief Nursing Officer. CW #8 was responsible for all Western's ER operations including designing a plan to address Western's overwhelming number of ER patients. CW #8 was hired by CHS to "fix problems" in the ER at Western relating to the large number of patients coming through the ER, which was "one of the busiest in the country." CW #8 explained that CHS's

case and risk managers from headquarters would send the Blue Book "in bulk" and the staff kept them on their desks. CW #8 stated that the ER staff would always refer to the Blue Book for any patient that came into the ER to see if the patient qualified for admission.

89. By creating and adopting the Blue Book, CHS rejected two widely accepted sets of admissions criteria which are used by over 75% of the hospitals in the United States, namely, InterQual criteria and the Milliman Care Guidelines ("Milliman"). InterQual was developed by an 1,100-member panel of independent physicians and medical professionals, is used by is used by approximately 3,700 hospitals, CMS[5], state Medicaid programs, Medicare Quality Improvement Organizations in 40 states, and various Medicaid payers and private health plans. Milliman is used by 1,800 of its clients, including over 1,000 hospitals, 25 CMS auditors and 7 of the 8 largest U.S. health plans.

90. Together, InterQual and Milliman are used by over 75 percent of all hospitals in the United States, with approximately 60 percent using InterQual and approximately 16 percent using Milliman Care Guidelines.

91. As revealed in the *Tenet Litigation*, the Blue Book has none of the attributes of the InterQual or Milliman Care Guidelines. Rather, the Blue Book

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[5] In September 2011, CMS (the federal agency responsible for administering Medicare and other programs) announced that for the twelfth consecutive year that it would be using InterQual for its Medicare inpatient auditing programs.

is a small 40-page booklet that sets forth the "Admission Justification[s]" for the most common medical conditions presented by CHS patients. CW #2 noted that the Blue Book was "child-sized" and "obviously over simplified." The Blue Book is not independent or objective, but rather was developed by CHS and, upon information and belief, has never been externally tested by physicians unaffiliated with CHS. Unlike InterQual or Milliman, the Blue Book lacks a single reference to a medical journal or other resource, and its criteria for admitting patients into the hospital are demonstrably more lenient, general, and subjective than the evidence-based criteria used throughout the rest of the industry. Indeed, in many cases the Blue Book contains admissions criteria where there is no clinical basis to admit the patient.

92. According to CW #3, a former ER Director at Haywood, CHS took the typical chest pain protocol contained in the Blue Book to "a new level." CW #3 stated that CHS would order EKGs and enzyme tests; family histories and secondary illnesses would be recorded in order to generate a higher acuity level and, thus, more revenue for CHS even though it was unnecessary. CW #3 stated that this was done because CHS was able to get higher reimbursements for that type of patient.

93. The purpose of CHS's Blue Book criteria and admissions practices was clear: by admitting patients who, under accepted clinical criteria utilized throughout the hospital industry, should have been treated in observation or sent home, CHS receives substantially more money from Medicare than if the patient had been treated in outpatient observation

status - an average of over $3,500 in 2009 - more per patient for CHS's highest volume and lowest acuity admitted patients, as found by Tenet. The financial impact is much higher for patients with less common conditions who are improperly admitted to a CHS hospital. As a result, taxpayers, insurers, businesses, and individuals have paid CHS hospitals more than they should for medical treatment.

94. The Blue Book contains far more subjective and liberal criteria for admitting patients into the hospital than the accepted clinical, decision-making, and evidence-based guidelines used by peer hospital systems across the country. A patient who visited a CHS hospital was, therefore, far more likely to be admitted on an inpatient basis than if that same patient visited any other hospital that properly admits patients on an inpatient basis based upon clinical need.

95. As a result, CHS created a culture at its hospitals where patients admissions were promoted whereas outpatient observation was discouraged, even in cases where it was medically preferable. CW #2 was told by hospital case managers that CHS's Vice President of Case Management had instructed them that "the goal was to get patients admitted using the Blue Book." According to CW #2, "*the goal was to get them admitted using the Blue Book. The goal was not to do 23 hours of observation. It was to admit (the patient) and start collecting the money*." These highly suspect practices were never disclosed to CHS's investors, causing millions of dollars in losses when CHS's stock plunged on the revelation of CHS's scheme.

96. On information and belief, even when CHS's patients were admitted on an inpatient basis but spent less than 24 hours in the hospital, CHS billed Medicare for an inpatient admission at a significantly higher cost than if the patient had been admitted on an outpatient observation basis. The Blue Book instructs CHS employees to admit patients on an inpatient basis and quickly discharge them after tests and treatment rule out serious medical conditions. This allows CHS to bill Medicare for far more than what would be actually justified by patients' medical needs.

a. Tenet's Complaint Contained Substantially Similar Allegations Regarding CHS's Adoption and Implementation of the Blue Book and the Resulting Increased Admissions at CHS

97. Tenet's revelations about CHS's practices and the Blue Book's lack of clinical foundation to support admissions were confirmed by Lead Plaintiff's investigation and have also been the subject of at least one *qui tam* action.

98. Tenet disclosed that for many conditions that are common among Medicare patients, the Blue Book includes admission justification criteria that (1) bear little relevance to determining the severity of a patient's condition; (2) are at odds with standard clinical decision-making for determining the proper level of care for patient and (3) provide an improper clinical basis for admitting a patient into the hospital.

99. The following examples, which were also analyzed and revealed in the *Tenet Litigation*, highlight the improper admission criteria as compared to objective clinical factors utilized by InterQual.

(i) Chest Pain

100. Upon information and belief, the Blue Book contains Admission Justifications that are either inappropriate or not relevant for physicians to consider in determining whether it is medically necessary to admit a chest pain patient to the hospital or whether the patient should be treated in observation. According to CW #3, if someone came into the ER complaining of chest pain, they were admitted. CW #3 added that "normally you would observe, monitor and do tests. Admitting everyone with chest pain is not the right thing to do. You want a doctor to make the decision not the company." CW #3 who participated in daily meetings with Haywood's CEO, Jeremy Gray, recalled discussing which patients would be discharged based solely on which patients may not be approved for payment. CW #3 specifically recalls admitting chest pain patients if their enzyme levels were elevated at all.

101. Upon information and belief, under standard clinical practice, when a patient presents to the hospital with chest pains, there are varying levels of care that may be provided to the patient, depending on the severity of the patient's condition. Given that chest pain is a very non-specific complaint, meaning that there are many causes of chest pain other than a heart attack, patients often are initially evaluated in observation in order to determine whether or not they are in fact having a

heart attack or suffering from a lack of oxygen to the heart. Many chest pain patients are appropriately treated in observation, where standard tests may be run to determine whether the patient has had a heart attack, in which case the patient likely would be admitted to the hospital, and if not, the patient would likely be discharged. Once a decision is made to admit a patient to the hospital, there are varying levels of care in the hospital depending on the severity of the patient's clinical condition. The initial level of care for stable patients requiring admission is the inpatient general medicine or surgical floor setting. Those requiring a higher level of care may be placed in a telemetry or intermediate care setting. Those patients that are most critically ill may be placed in the critical care unit.

102. The 2009 Blue Book sets forth three levels of care, and two levels of admissions for chest pain patients, each with separate "Admissions Justifications": 1) "Very Low Risk: Observation or Discharge;" 2) "lower risk/telemetry (Green/Blue cases);" 3) "high and moderate risk levels/CCU (Orange/Red cases)." As set forth below, for each of these categories of care, the Blue Book contains admissions criteria that are both inappropriate and inconsistent with standard clinical decision-making.

103. With respect to Chest Pain Observation, when a patient presents to the hospital with chest pain - one of the most common presenting emergency room complaints - it is accepted clinical practice to run two to three sets of blood tests on the patient every six to eight hours to measure the levels of cardiac enzymes (specifically, a cardiac marker known as troponin) in the blood. An elevated

troponin level from one test to the next indicates that the patient's cardiac wall likely has suffered a loss of blood flow, meaning that the patient is at risk of suffering or having suffered a heart attack. If, as is often the case, the patient's troponin level does not increase from one blood test to the next, the physician may rule out a heart attack and send the patient home. In addition, it is standard practice to perform two electrocardiograms ("ECGs"), which measure changes in heart rhythm that may be indicative of a heart attack-during the same time period that the cardiac enzymes are measured.

104. Because these cardiac enzyme tests and ECGs may be completed in less than 24 hours, it is standard practice for these patients to be treated in observation, rather than admitted to the hospital. Indeed, treating chest pain patients in observation is so common that some hospitals have observation units dedicated solely to evaluating patients complaining of chest pain.

105. While it is standard clinical practice to run these tests while the patient is in observation, the Blue Book justifies placement of a patient in observation only *after* the patient has two negative serial ECGs and two negative sets of cardiac enzyme tests. In other words, under the Blue Book, these tests may be run on patients already admitted to the hospital.

106. With respect to Chest Pain Telemetry Admissions, upon information and belief, the Blue Book Admission Justification criteria for chest pain, lower risk/ telemetry are at odds with standard criteria used in practice and justify admissions where, under accepted practice, patients would not

be admitted, but rather placed in observation or discharged. For example, a patient with chest pain may be admitted to the telemetry unit rather than placed in observation if he or she merely has a general risk factor for cardiac disease (*e.g.*, hypertension, diabetes, or hyperlipidemia) coupled with only one of the following:

(a) New chest pain in the presence of a significant history of coronary artery disease;

(b) A recent visit to the hospital with complaints of chest pain;

(c) Chest pain that may be reproduced by pressing on the chest; or

(d) "Atypical symptoms," such as shortness of breath, fatigue, sleeplessness and/or anxiety.

107. These Admission Justification criteria are weighted toward admissions and are inconsistent with accepted clinical standards for inpatient admissions, because many patients who present with chest pain have a history of a cardiac risk factor, such as hypertension (a very common diagnosis in the U.S. population and not necessarily indicative of a medical need for inpatient care). Furthermore, the criteria identified in (a) through (d) above are very different from the accepted clinical standards for hospital admission, such as having positive cardiac enzymes. For example, the Blue Book treats a "recent visit to the hospital with chest pain" as a criterion for admission. While it is certainly a part of a patient's history, it is not any indication of a patient's clinical severity of illness. Upon

information and belief, none of these criteria are representative of standard clinical criteria that physicians consider when deciding whether to admit a patient with chest pain to the hospital. Moreover, under InterQual, these Blue Book criteria would not support the admission of a patient to the hospital.

108. With respect to Chest Pain Cardiac Care Unit ("CCU") Admissions, the same is true for the Blue Book criteria for admission. The CCU is reserved for patients with the most critical medical conditions who require intensive and rapid treatment for survival. The Blue Book Admissions Justification criteria, however, include, on information and belief, many diagnoses that have no bearing on the severity of the patient's existing illness, but rather, address only the patient's medical history or conditions that are common among many chest pain patients - conditions that should have no bearing, under standard clinical practice, on whether a patient should be placed into the CCU rather than simply admitted to the general medical floor. For example, the Blue Book Admission Justification criteria for admission to the CCU include several criteria, two or more of which must be met to justify an admission to the CCU. Several of these criteria, upon information and belief, are out of line with standard clinical decision-making, including the following:

(a) A history of smoking, hypertension, hyperlipidemia, or diabetes;

(b) Two or more episodes of pain;

(c) Oxygen saturation less than 90;

(d) Rest angina less than 20 minutes (resolved with rest or nitrates); and

(e) Indeterminant CKMB or Troponin.

109. Upon information and belief, each of these criteria is not relevant to the determination of whether care in the CCU is medically necessary. For example, whether a patient is a smoker or has hypertension, for example, has no bearing on the severity of the patient's condition and certainly does not inform the need for CCU admission. Further, upon information and belief, chest pain patients frequently present with two or more episodes of pain, meaning that this criteria is not indicative of the severity of a patient's chest pain necessary to require the highest level of care. In addition, having a patient with an oxygen saturation less than 90 is extremely common, not in and of itself life threatening, and easily treatable with supplemental oxygen. When a short period of rest angina occurs and is resolved with rest or nitrate therapy, there is no medical necessity of treating such patients in an intensive care setting, which is reserved for the most critically illpatients. And whether the results of a patient's CKMB or troponin levels are "indeterminant" is not, under standard clinical practice, a justification for admitting the patient into the CCU, but rather, an indication that further testing should be performed.

110. In sum, in many cases where the Blue Book criteria inappropriately warrant a hospital admission for a chest pain patient, current accepted clinical practice standards justify placing the patient in observation status. In the case where patients present with chest pain, the standard of care through

an electrocardiogram and cardiac enzyme blood testing may be used to determine whether or not a patient may be having a heart attack. If so, then patients may then be admitted to the appropriate inpatient setting and appropriate level of care intensity. Patients that are ruled out for an acute heart attack, as the vast majority of "chest pain" patients are, may be discharged home.

(ii) Syncope or Pre-Syncope

111. In addition to Chest Pain, the Blue Book's Admissions Justifications include many criteria that are inappropriate for determining whether a patient with pre-syncope or syncope (dizziness or fainting) should be admitted to the hospital or should instead be treated in observation.

112. Under standard clinical practice, when a patient presents to the hospital complaining of dizziness (pre-syncope) or fainting (syncope), the physician performs several tests to eliminate any critical causes that may be responsible for these episodes, such as the potential for a heart attack, a stroke in the brain, or some form of structural heart disease or acute heart arrhythmia. These tests are standard "in most hospital settings and can be performed within a 24-hour period. Such patients typically are placed in observation so that these critical, though rare, causes of syncope may be ruled out. Once they have been, syncope or pre-syncope is often due to dehydration (as determined by measuring a patient's drop in blood pressure between lying down and standing up) or by a vasovagal reaction (a very common cause of fainting in adults). Both of these etiologies are much less critical and can be treated simply in observation.

Patients with dehydration will be rehydrated during their observation stay through IV fluids, and, as long as the syncope does not recur, will be sent home. Patients with vasovagal episodes will follow up with their primary care physician as an outpatient, with further treatment if the episodes recur. Regardless, these patients typically are treated in observation.

113. Rather than treat these patients on an outpatient basis, the Blue Book Admission Justification criteria call for the admission of a patient who has an episode of fainting and is over the age of 60. Upon information and belief, age is irrelevant in the case of syncope. Regardless of the etiology, age is not a risk factor for syncope, and all patients, regardless of age, will undergo the same workup and battery of testing discussed in the previous paragraph, which are appropriately conducted in observation. Additionally, the Blue Book admissions criteria include patients who have a "Postural BP greater than 15 mm," indicating that patients found to have a positive "orthostatic testing" (such as a drop in BP of greater than 15mm Hg between a standing and sitting position) may be admitted. However, such a blood pressure drop may be due to dehydration, which is something easily treated in an observation status with intravenous ("IV") fluids and rehydration. Once again, this criterion is not a clinically accepted standard of care for determining whether it is medically necessary to admit a patient to the hospital.

114. In comparing InterQual to the Blue Book, InterQual states that the criteria for observation are, as described above, pre-syncope or syncope of unknown etiology. Upon information and belief, this

is appropriate and consistent with accepted standards of clinical care. Further, once a patient is found to have a more critical cause of syncope, such as structural heart disease or an arrhythmia, InterQual indicates that it is reasonable to admit such patients to the hospital, but the majority of patients are simply dehydrated, treated with IV fluids in observation, and discharged home.

(iii) Community Acquired Pneumonia ("CAP")

115. The next example of where the Blue Book justifies patient admission, but the standard accepted practice does not, involves Community Acquired Pneumonia ("CAP"). On information and belief, the Blue Book's Admission Justifications criteria ignore accepted clinical practices for determining whether a patient presenting with CAP is ill enough to require inpatient treatment, or whether the patient could, instead, appropriately be treated in observation.

116. Admission of a patient with CAP is justified under the Blue Book if the patient presents with a cough and rales (the presence of fluid in the lungs). However, on information and belief, many patients who have pneumonia - regardless of severity - have the presence of a cough and rales on exam. Thus, the mere existence of these findings tells the physician nothing about whether a patient presenting with a cough and rales has a clinical picture that correlates with severity of illness requiring admission to the hospital.

117. Similarly, an admission of a patient with CAP is justified under the Blue Book if the patient

presents with a cough and infiltrate or atelectasis. On information and belief, the mere existence of a cough and abnormal chest X-ray is only relevant to informing the physician that the patient may have CAP; standing alone, the presence of these findings provides information on a possible diagnosis, but does not justify hospital admission. Clinical presentati9n, a critical component of the decision-making process regarding admission or observation, is not taken into account in the Blue Book.

118. Under InterQual, patients presenting with a cough and rales or an abnormal chest X-ray would not, absent other symptoms, be admitted to the hospital for treatment. Instead, such patients would be examined to determine whether they have an elevated breathing rate, a fever, or a high white blood cell count, and most importantly, whether the patient is 65 or older. In the absence of serious additional criteria (for example, a breathing rate above 29), the patient would be treated in observation with IV antibiotics and monitored for up to 24 hours for improvement. In the typical case where the patient responded favorably to such treatment, the patient would be sent home, and if the condition worsened, the patient would be admitted to the hospital.

119. Finally, the Blue Book permits the admission of a CAP patient who presents with a cough and a temperature of 102 degrees with a white blood cell count of 15,000 or greater. On information and belief, it is well accepted, however, that a patient's temperature and white blood cell count do not necessarily have a strong correlation with the severity of disease without consideration of age and

presence of co-morbidities. Thus, absent other factors (such as advanced age or a disease that weakens a patient's immune system), there is no absolute clinical basis for inpatient admission when a pneumonia patient has an elevated temperature and white blood cell count.

(iv) Cellulitis

120. On information and belief, the Blue Book's Admission Justification criteria also are deficient when applied to patients presenting with signs of cellulitis, an infection of the skin that can cause pain, fever, and elevated white-blood-cell counts. For example, a patient presenting with a possible cellulitis and either an elevated white blood cell count and a temperature over 102 degrees, or a "weeping wound," may be admitted to the hospital. On information and belief, these admission criteria fall outside accepted clinical practice as they individually do not provide evidence as to the severity of a patient's cellulitis. A patient presenting with only these conditions would not, under InterQual, be admitted to the hospital. On information and belief, such patients would either be effectively treated with IV antibiotics in observation for 24 hours and discharged when their condition improved, as cellulitis often does with 24 hours of antibiotic treatment, or would be given one dose of IV antibiotics in the emergency room and sent home with antibiotics by mouth and a follow up appointment soon after the ER visit.

121. The Blue Book Admission Justification criteria ignore the important inquiry regarding complexity and severity of cellulitis, a question that doctors often face when determining whether a

patient may be treated in observation or admitted to the hospital for treatment, and the length of time that would be required to treat a cellulitis patient with IV antibiotics. On information and belief, this determination is driven by the part of the body that is affected (cellulitis of the face, hand, or foot is more difficult to treat than the upper arm, thigh, or calf); co-existing medical conditions of the patient (patients with diabetes face greater risk associated with cellulitis, often supporting inpatient treatment); and signs of sepsis or shock (patients with low blood pressure, acute confusion, or bacteria in the blood are at the highest risk for complications). These widely accepted clinical factors are primary considerations under the InterQual admissions criteria, but under the Blue Book, less clinically relevant factors are considered to justify inpatient admissions.

122. In sum, CHS ignored Medicare rules by creating a liberal and over-simplified set of ER admissions criteria and enforcing admissions practices that steer its physicians to inappropriately admit patients on an inpatient basis rather than observation status, and disregard the clinically-based standard of dispensing only "reasonable and necessary" or "medically necessary" care. Accordingly, a patient who visits a CHS hospital was much more likely to be admitted into the hospital than if the same patient visited any other hospital that admits, as is proper only on the basis of clinical need.

b. The *Qui Tam* Action Contained Substantially Similar Allegations

123. On January 7, 2009, the *Qui Tam* Action was filed under seal in the Northern District of Indiana. The *Qui Tam* Action was subsequently unsealed on December 27, 2010, but was not disclosed by CHS until after Tenet filed its complaint in April 2011. The *Qui Tam* Action contains substantially similar allegations to those contained herein and in the *Tenet Litigation* regarding CHS's use of the Blue Book to improperly boost its ER admissions.

124. Specifically, the Relator Nancy Reuille (the "Relator") in the *Qui Tam* Action was a former Supervisor of Case Management who worked at Lutheran Hospital of Indiana ("Lutheran") from 1985-2008. The Relator alleged, under oath, that prior to CHS's acquisition of Triad, Lutheran, then a Triad hospital, was proactively auditing its inpatient short stays and was writing off Medicare reimbursements averaging $50,000 or more per month for admissions that should have been observations. The Relator's suit further alleges that after CHS acquired Triad, CHS "abruptly" halted these reimbursements because they constituted "a monetary loss CHS would not permit," and proceeded to impose "questionable medical criteria [CHS] devised and [is] different than that established by Medicare, *i.e.* Blue Book v. InterQual criteria."

125. The Relator also alleged that immediately after CHS acquired Lutheran, there had been "a dramatic decrease in the volume of '23 Hour Observation' cases" and a dramatic increase in the number of "inpatient" one-day hospitalizations.

126. The Relator further alleged that when CHS acquired Lutheran, Bill McCray (CHS's Case Management supervisor), told the Relator that "CHS has an intense focus on case management and that they would all require education on CHS medical criteria contained in the corporation's "Blue Book." The Relator also alleged that she found the Blue Book "exceptionally simplistic and nonspecific." She further alleged that "according to the Blue Book virtually any case could be construed as meeting "inpatient" medical criteria to detriment of the federal government."

127. Thus, similar to the allegations here, the *Qui Tam* Action alleges that CHS, as part of its scheme, was using the Blue Book to boost its "one-day stays" for Medicare patients at Lutheran Hospital in order to increase its revenues. At no time did CHS or any of its senior officers disclose to its investors that it was engaging in such improper, and potentially illegal, practices.

2. CHS and its Senior Leadership Rigged Pro-MED To Drive Improper Inpatient Admissions From Its ED

128. CHS's culture of improperly driving up inpatient admissions rates for financial rather than clinical reasons is further demonstrated by its programming of Pro-MED to prompt medically unnecessary testing to raise patient acuity levels. Pro-MED is used by CHS to track a patient from the moment they enter the ER, and, as acknowledged in the Company's Form 10-Ks, to assist physicians in making diagnoses and determining treatments. Specifically, when a patient presents to a CHS hospital ED, the patient's information, including

medical symptoms, are entered into Pro-MED by the ED medical staff. Based on these inputs, Pro-MED will alert the ED physician and staff to conduct particular tests or provide particular treatment to the patient based on the patient's symptoms.

129. CHS mandated that Pro-MED be installed in every ED, including the 50 hospitals that CHS acquired from Triad in July 2007. CW #1 explained that the Revenue Committee decided to boost ED admissions by: (1) dispatching a half dozen "clinical documentation specialists" to each CHS hospital to train the ER doctors and nurses how to write their orders in patient charts to justify admissions; and (2) making programming adjustments to the Pro-MED Software in order to generate more tests based on a patient's initial diagnosis, even though medically unnecessary, which would result in raising a patient's "acuity level" in order to justify an admission.

130. CW #1 recalled that the "documentation specialists" taught the staff the correct "verbiage" to use on the "T sheets" (which are handwritten medical records), and in electronic formats, to prompt admissions and to survive a possible audit by the CHS compliance department or by outside auditors.

131. CW # 1, who was CHS's Charge Master Manager, explained that, based on a patient's initial diagnosis, Pro-MED ordered a certain panel of diagnostic tests, such as MRI scans, CT scans, blood tests, and other tests. CW #1 explained that the ER staff at each CHS hospital were required to follow Pro-MED's orders.

132. CW #1 revealed that, at the direction of her managers, she made "adjustments" to CHS's "Charge Description Masters" in order to generate a more comprehensive battery of medically unnecessary tests to generate higher billings and to increase the potential that Pro-MED would prompt an admission of a patient.

133. In addition to the "adjustments" that resulted in more diagnostic testing, CW #1 programmed Pro-MED, at the direction of senior CHS executives, to raise the "acuity levels" of its ER patients in order to justify admissions.

134. CHS's senior executives orchestrated this scheme from its headquartrs. CW #1 occasionally attended the weekly meetings held by CHS's Revenue Committee where her supervisor, Plattner, and senior executives discussed strategies to boost admissions and to reduce the less lucrative observations. CW #1 recounted that, at these meetings, the Company's senior executives discussed what changes could be made to Pro-MED in order to boost admissions and reduce observation periods. CW #1 would then make the changes to Pro-MED, *i.e.*, modifying patient testing and procedures in order to raise acuity levels and prompt admissions for patients who otherwise would not qualify for admission.

135. In particular, CW #1 recalls being approached by Defendant Larry Cash (CHS's Chief Financial Officer) from time to time about how CW #1 could change Pro-MED to increase the "census" (*i.e.*, occupancy rate) at specific CHS hospitals. Modifying Pro-MED to boost admissions was also discussed at other Company meetings. CW #1

participated in monthly conference calls with a larger group of hospital financial officers, nursing directors, health information management directors and others from CHS's hospitals and EDs. These monthly conference calls were organized by CW #1 and regularly recorded by Premiere, an outside vendor that would prepare CDs and/or transcripts of the calls and return them to CW #1. Shortly thereafter, CW #1 would send copies of the CD's or transcripts to hospital staff. One of the purposes of these conference calls was to discuss Pro-MED and strategies to increase admission revenue.

136. CW #1 recalls one male patient that presented to the ER of the Woodward Regional Hospital in Woodward, Oklahoma with a nose bleed in September, 2008. This patient was treated, given medication, and held in observation status. Although his chart showed that his pain was subsiding and that he had no reactions to the medication, CHS changed his acuity status to "level 5" and admitted the patient into the Woodward's intensive care unit ("ICU"), instead of discharging him.

137. CW #1 was also responsible for the training of ER staff at CHS hospitals in the use of the correct codes for the Pro-MED system. In particular, CW #1 was responsible for training CHS employees about CHS policies and procedures for billing Medicare and other insurers for the services CHS rendered.

138. CW #1 further explained that the changes to Pro-MED and specific training of ER staff were accomplished in a manner that was intended to escape detection. CW #1 recalled CHS's executives asking whether the changes made to Pro-MED would "survive an audit." CW #1 further stated that CHS's

senior executives "saw a way to make more money and they took it to Wayne Smith for approval."

139. The information provided by CW #1 was substantially corroborated by another confidential witness. According to CW #3, the Pro-MED software system used in the ER assigned a score to each test or procedure, or number values for each action taken. CW #3 indicated that a printout was generated which showed the "level" of illness for each patient, which included five levels – 1 through 5. Level 5 patients were admitted or transferred to another CHS hospital. Level 4 patients "were a gray area." Level 3 or lower patients were normally discharged. CW #3 stated that whether a Level 4 or 5 patient was admitted was "sticky" because if a particular patient's problem was resolved in the ED, there would be no reason to admit them. However, CW #3 stated that in most cases CHS "admitted [them] anyway."

140. CW #3 further stated that CHS provided nurses "with little notes on how to bump the levels up." By administering more tests, the Pro-MED system was programmed to bump up the patient acuity levels making it more likely that he patient would be admitted.

141. CW #4 confirmed that Pro-MED probably prompted an increase in admissions at the hospital and that Pro-MED made some doctors "nervous." CW #4 recalls one physician, Dr. Kaye Evans, questioning the automatic orders for some diagnostic tests and the prompting of admissions issued by Pro-MED.

142. As further alleged by Tenet, as the patient is treated, Pro-MED was also programmed to raise flags that require some form of treatment or testing by the physician before the flag may be removed. On information and belief, Pro-MED often raised a flag despite there being little or no clinical need for the physician to provide treatment required to remove the flag, which generated substantial revenue for the CHS hospital. Although, on information and belief, Pro-MED did not require that a physician perform a particular test on a patient, Pro-MED would raise flags to identify when a patient has a symptom that requires some type of treatment or test result before the flag may be removed. Importantly, it was CHS's policy that a patient should not be discharged from the ED when one or more flags remained for a patient. While physicians could "check off certain of the flags, some could not be removed. Thus, even if the ED physician believed that a patient should be discharged notwithstanding an ongoing symptom (because the physician independently concluded that there was a clinical reason to override CHS's non-clinical interpretation of the symptom in Pro-MED), under CHS policy, the patient should be admitted to the hospital, rather than discharged. Although the physician could still send the patient home, he or she did so knowing that CHS tracks the number of patients each physician discharges with flags-even, if, according to standard clinical practice, sending the patient home is the right thing to do. On information and belief, if an ED physician continued sending patients home with (non-clinical) flags, the CHS hospital would request that the company providing the ED doctors to the CHS hospital replace such an ED physician with a physician more willing

to follow CHS policy and admit patients with CHS-derived flags.

143. While Defendants publicly touted CHS's ability to boost ED admissions rates through the standardized use of the Pro-MED system and, in particular, at the newly-acquired Triad hospitals, they failed to disclose throughout the Class Period that ED admissions growth had been achieved in large part through use of the Blue Book's non-standard criteria and the fact that Pro-MED was programmed to steer physicians and case managers to testing and treatments that were not medically necessary, in order raise patient acuity levels to justify patient admissions.

3. CHS's Quotas and Financial Incentives, Along with its Enforcement Mechanisms, Ensured that CHS Personnel Met Admissions Targets

144. In addition to utilizing the Blue Book and rigging the Pro-MED system to improperly drive up admissions at its hospitals, CHS adopted a strategy of setting admissions targets for its hospitals, incentivizing hospital administrators to meet admissions targets, and holding its medical staff accountable to those admission targets.

145. According to a CW #3, who was an ED Director, CHS had a goal of achieving a 20% admission rate in the ED. Specifically, as part of CW #3's responsibilities, she attended daily meetings with Jeremy Gray, the CEO of Haywood Park and other employees of that hospital facility. At those meetings, the CEO regularly issued a directive stating that he wanted a 20% admission rate from

the emergency room. CW #3 believes this "directive" originated from CHS's corporate office.

146. According to CW #3, CHS's "quota" was very difficult to meet because the ER only saw about 20 patients per day. In addition, CW #3 said that CHS was "very numbers focused and the [quota] was a pain to deal with." CW #3 added that "the nurses used to joke 'should we put a sign outside saying free beer to get patients in the ER.'"

147. CW #3 also revealed that CHS gave admission staffers "prizes and bonuses" to those who collected the money from ED patients. CW #3 added that, although she did not receive a bonus, CHS case managers were eligible for bonuses.

148. CW #2 also confirmed CHS's employees incentive program. CW #2 stated that Regional Managers and Hospital Supervisors received bonuses based on the percentage of Medicare patients admitted and how much revenue they brought in. CW #2 explained that CHS wanted Medicare admissions and "if you didn't produce you were done."

149. Another former employee, referred to herein as Confidential Witness #9 ("CW #9"), worked as a Finance Manager and as an Assistant Chief Financial Officer for three CHS hospitals (Phoenixville, PA Hospital, Chestnut Hill, PA Hospital and Brandywine Hospital located in Coatesville, PA) from 2002-2006, and was responsible for implementing productivity systems and benchmarking programs to boost hospital admissions at each of these hospitals. On information and belief, CW #9 reported to the

hospital CFO and participated in weekly conference calls with Division Director Gary Link, in which each CHS hospital reported their financial results, including "census", revenues, and budget goals. CW #9 stated that "CHS tried to manage their inpatient admissions through their Emergency Departments." CW #9 further stated that CHS pushed ED doctors at the hospitals where he worked to admit patients, rather than keep them in observation status.

150. As another example of CHS's "admit at all costs" strategy and measures it took to enforce quotas, in at least one hospital, CHS criticized its staff when it learned of ED transfers to non-CHS hospitals, even when it was determined that CHS's ED did not have adequate resources to treat the most critical patients. According to CW #8 a former Director of Emergency Services, who was responsible for all ED operations at Western, the CEO at that hospital would question the ED staff decisions to "transfer any patients." CW #8 stated that Western's CEO told CW #8 that he was "catching heat from corporate" and that "[t]here was corporate pressure on him to keep these patients in the hospital. . . . And [corporate] did not want to see valuable dollars go out the door." CW #8 stated that this facility's ED saw a high degree of traumatic injuries and not enough beds or medical staff to treat them all which made transfers necessary. Despite this, CW #8 explained that the CEO still criticized the transfers by having "temper tantrums" and stating that "corporate doesn't like the fact that we are transferring all these patients."

151. Tenet also alleged that CHS employed similar financial incentives and enforcement

mechanisms. Tenet revealed that CHS set targets for each of its hospitals to convert ED patients into admitted patients. These targets, which typically are posted in plain view throughout the hospital (in the lunch room, for example), are based not on the medical needs of a hospital's patients or, critically, the patient mix of a particular hospital, but on an artificial goal meant to increase each hospital's admission rate. Tenet also revealed one example that illustrates the impact of CHS's scheme. At Mat-Su Regional Medical Center – a former Triad hospital – the admission rate for many years had been approximately in the 9 to 10 percent range. Notwithstanding the relatively young population in the immediate vicinity - meaning fewer elderly patients who are more likely to require an appropriate admission to the hospital. CHS management set an admission target at Mat-Su of 12 to 15 percent, and expected the hospital's ED doctors to meet that goal. With this improper emphasis on increased inpatient admissions (and restricting outpatient status), Tenet disclosed that that in the year following CHS's acquisition of Mat-Su, the hospital's observation rate plummeted from 10.01 % to 2.83% -a stunning 72% one-year drop.

152. Tenet's investigation also revealed that CHS physicians and ED doctors also received bonuses based, in part, "on the number of patients admitted to the hospital part of CHS's goal of converting between 17 and 20 percent of all ED visits to inpatients." By establishing these artificial targets, CHS ignored that patients should be admitted to the hospital from the ED based on their clinical indications and needs, and not based on maximizing profits.

153. Defendants failed to disclose to investors that CHS established a "quota system" at its EDs, a practice which if revealed, would have drastically altered its reputation in the industry, as well as the value of the Company's stock.

154. In order to further its scheme, CHS regularly tracked each ED physician's individual admissions rates and scrutinized the conduct of ED physicians who failed to meet CHS's admission targets. CW #9, stated that the admission practices of the ER doctors in the emergency department were tracked by the hospital's CEO. CW #9 indicated further that if an ER doctor appeared to be admitting too few patients compared with his colleagues, the CEO would arrange a meeting with the under-performing physician to discuss his or her low admission rate. CW #9 stated that there was "definitely pressure to make your budget goals to make sure they weren't leaving money on the table." Even more astounding, CW #9 recalled that the CEO and the Emergency Department Director would "pull the patient's records and see if there were any issues and why the doctor failed to admit."

155. CW #4 confirmed that at Payson hospital there was "pressure to admit patients to increase the 'census' [CHS's occupancy rate]." In addition, CW #4 revealed that the CEO of Payson, Chris Wolf, "would talk to the ER physicians and nurses about the need to increase admissions to improve the census."

156. As Tenet alleged, this system created a culture in which ED physicians were persuaded by CHS to admit patients whose medical conditions did not require inpatient care. Further, Tenet revealed that a former CHS senior executive "regularly

instructed individual CHS hospital CEOs, at quarterly orientation and annual CEO meetings, that physicians at CHS hospitals were required to use the Blue Book to achieve higher inpatient conversion rates in CHS EDs and to avoid the use of observation status." Tenet also alleged that physicians were terminated for failing to meet the admission targets.

157. Tenet also revealed that, taking it one step further, in order to comply with the ED admissions "quota" system in place at CHS, hospital administrators would "frequently reverse physician decisions to place patients in observation status." As an example, Tenet noted that at DeTar Healthcare System in Victoria, Texas-a former Triad hospital, the hospital's CEO, William R. Blanchard, made clear to hospital staff, doctors, and case managers that it was essential to adhere to CHS's policy of admitting patients to the hospital, rather than placing them in observation status, because the hospital would earn substantially more revenue for inpatient treatment. On information and belief, during the 2008 and 2009 time frame, the DeTar executive staff held daily "flash" meetings during which the staff would present to Blanchard, among other things, patients who had recently been placed into observation status. Upon learning this information, Blanchard would, during the flash meeting, call the physician who placed the patient into observation status and instruct the physician that the patient should be removed from observation and admitted to the hospital. Unsurprisingly, in the year following CHS's acquisition of DeTar, the observation rate at DeTar plummeted by over 47%.

158. In sum, by setting lofty admission targets, tracking ED physician admission rates, rewarding or punishing ED physicians and staff based on their compliance with artificial targets, and, in some cases, reversing the decision by ED physicians to place patients in observation status rather than admitting them as inpatients, CHS management created a unique culture in which patients were admitted to the hospital despite no medical need for inpatient treatment.

L. CHS's Admission Rates Diverge Dramatically From its Competitors

159. The foregoing strategies demonstrate how CHS actively worked to systematically drive up inpatient admissions and drive down outpatient observation admissions. When CHS's observation and admission rates are compared to the industry in general and to well-known hospital operators that compete with CHS, the success of CHS's improper practices becomes readily apparent.

160. Tenet initially retained two "leading" healthcare consulting firms, including Avalere Health LLC ("Avalere") to study how CHS's observation and admission rates compared to other well-known hospital systems. Avalere analyzed publically available data from CMS while Tenet's other consultant analyzed data from the American Hospital Directory. Both Tenet consultants reached "substantially similar conclusions." Lead Plaintiff subsequently hired its own industry specialist who has analyzed the CMS database and independently confirmed the conclusion of Tenet's experts.

161. Specifically, statistical analyses performed by Tenet's consulting firms revealed that in 2009, CHS's outpatient observation rate was less than half the industry average. In fact, nearly 95 percent of CHS's hospitals had outpatient observation rates below the national average, with nearly 70 percent of CHS's hospitals more than 50 percent below the national average.

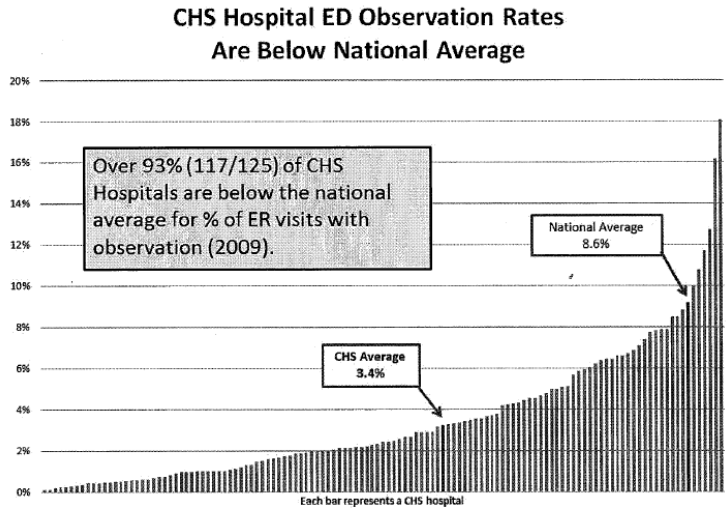
162. CHS's failure to treat patients on an outpatient observation basis is particularly surprising because, according to industry data revealed by Tenet, CHS's patients generally present with less severe symptoms, or lower acuity, than the national average. Specifically, on information and belief, the average CHS hospital has a lower case mix index ("CMI") (CMI of 1.28) than the national average inpatient short-stay acute care hospital (CMI of 1.43). Hospitals with lower CMI are expected to have a higher rate of outpatient observations, but CHS has a below-average outpatient observation admission rate and a below-average CMI. CHS's low outpatient observation rate, despite its lower acuity patients, evidences CHS's improper admissions practices.

M. Lead Plaintiff's Statistical Evidence Shows That CHS's Strategies Were Extremely Effective and Resulted in Admission and Observation Rates That Diverged Dramatically From Its Competitors

163. The indings of Lead Plaintiff's healthcare consultant are substantially consistent with those of Avalere's as follows:

1. CHS's Observation Rate vs. Industry

164. Tenet alleged that CHS's Medicare observation rate was "*less than half the industry average*" in 2009 and that more than 90% of CHS's hospital fell below that national average. Lead Plaintiff s healthcare industry specialist's analysis is consistent with this finding. As shown below, CHS 's Medicare observation rate in 2009 was 60% below the national average.

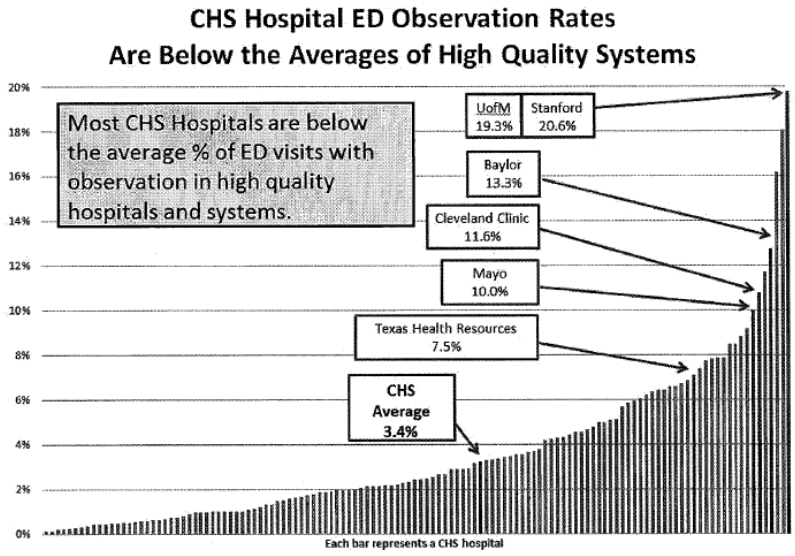


165. The analyses performed by Lead Plaintiff's healthcare industry specialist demonstrate system-wide differences in performance between CHS and its industry peers that cannot be attributed to a few outlier hospitals that skew the averages. Rather, the findings show that 93%, or 117 out of 125 CHS hospitals, were below the national average for the percentage of ER visits with observation.

2. <u>CHS's Observation Rate vs. Average of High Quality Systems</u>

166. Tenet's expert found that CHS's Medicare observation rate in 2009 was "significantly below the rates at some of the most highly respected not-for-profit hospitals in the country."

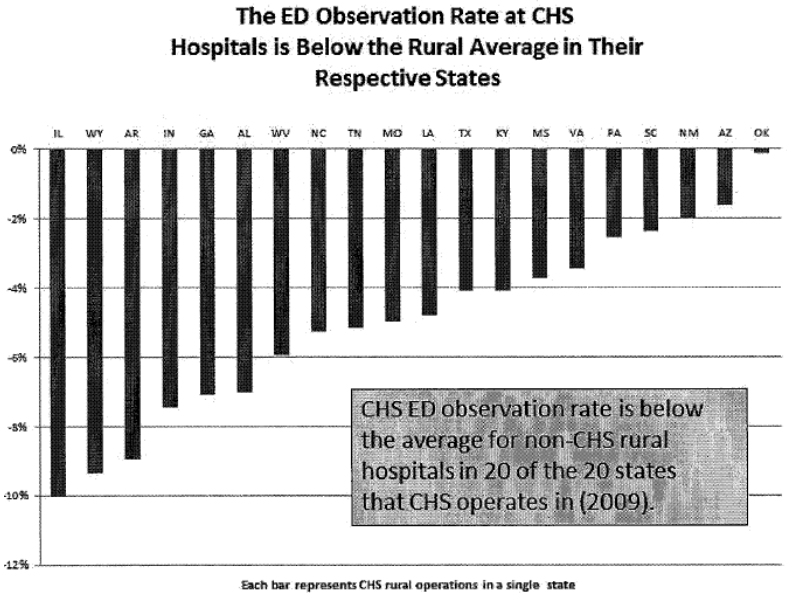
167. Lead Plaintiff's healthcare industry specialist's analysis is consistent with this finding. As shown below, CHS's 2009 Medicare average observation rate is 55% to 83% below the averages of High Quality Systems:[6]



[6] High Quality Systems included the following: the Cleveland Clinic, Stanford, Texas Health Resources, the Mayo Clinic, Baylor, and the University of Michigan.

3. CHS's Observation Rate vs. Rural Hospitals in Same Geographic Area

168. Tenet alleged that CHS's "rural hospital base" could not explain the low Medicare observation rate in 2009 relative to the industry. Tenet's data showed that CHS's Medicare observation rate of 4.89%, was significantly lower than other rural hospitals in the same geographic area. Again, Lead Plaintiff s healthcare industry specialist's analysis is consistent with this finding. As shown below, the Medicare observation rate in 2009 at CHS hospitals was far below other rural hospitals in 20 out of 20 states in which they operate:

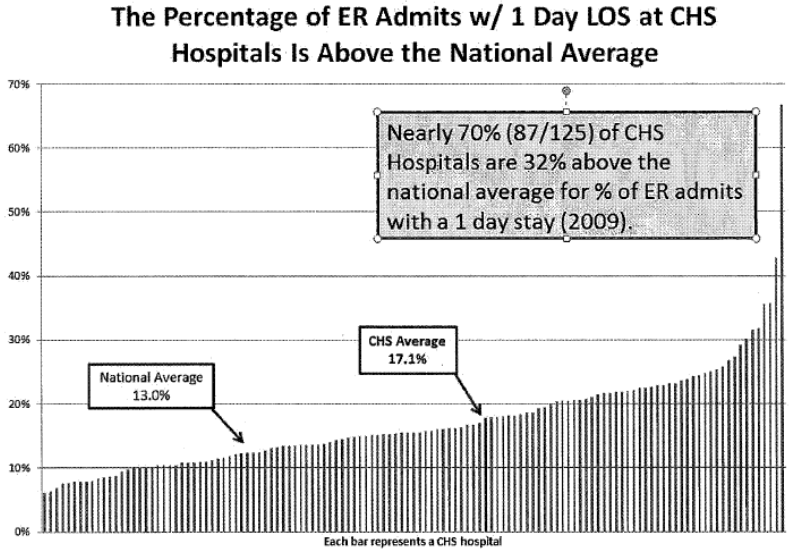


4. Disproportionate Share of CHS's Admissions are "One-Day Stays"

169. Tenet alleged that, as result of CHS's improper admissions of patients who should have been observed, CHS has a "higher than average

percentage of admitted patients who are discharged after just a single day in the hospital – a metric that Medicare considers a red flag for patients who may not have required treatment on an inpatient admitted status."

170. Lead Plaintiff's healthcare industry specialist analyzed CHS's admission of patients with "one-day stays" as compared to the national average. Hospitals with a high rate of short "one-day stays" are considered "red flags." Its analysis found that nearly 70 percent of CHS hospitals admitted ER patients for one-day stays at an average rate of 32% higher than the national average:



171. The testing performed by Lead Plaintiff's healthcare industry specialist not only confirms much of the analysis conducted by Tenet's consultants, but also establishes substantial differences in admissions and observation rates at

CHS and comparison groups of hospitals over an extended time period.

172. For example, Lead Plaintiff's expert's analysis of data for the three year period from 2008-2010 revealed that CHS hospitals' have an average for ER visits with observation was 58% lower than the average rate for large systems and 77% below the average observation rate for quality hospital systems for this time period. Conversely, hospitals average ER admission rate of during this three year period was also 25% higher than the average admission rates for quality systems and 22% higher than larger systems.

173. These statistical analyses and evaluation of CHS's business practice leads to the inescapable conclusion that patients whose medical needs likely required treatment in outpatient observation status were systematically admitted for higher-paying inpatient care at CHS hospitals.

N. CHS's Medicare Manipulation Enhanced the Company's Growth by Acquisition Strategy

174. CHS multiplied the effects of its Medicare billing manipulation to its maximum benefit through its strategy of acquiring hospitals and increasing revenue from these hospitals by immediately lowering their outpatient observation admission rates and increasing their inpatient admission rates through manipulative admission practices.

175. As disclosed by Tenet, CHS's growth-through-acquisition strategy is best illustrated through its July 2007 acquisition of Triad, which operated approximately 50 hospitals in 17 states. As

noted above, immediately following the acquisition, former Triad hospitals were required to adopt CHS's non-standard Blue Book criteria for patient admissions and employ the Pro-MED system. The immediate impact of CHS's Blue Book practices and use of Pro-MED to generate a battery of medically unnecessary tests on Triad hospital admission rates was stunning: within one year of the acquisition, the outpatient observation rate at the former Triad hospitals dropped 52 percent, while the admission rate jumped by about 33 percent. This dramatic swing was due in large part to CHS's practice of improperly admitting patients on an inpatient basis who, under Triad's pre-acquisition admissions criteria, would have been appropriately treated on an outpatient observation basis.

176. CHS's practice of inflating its revenues grew increasingly risky in recent years. Since 2007, the U.S. Department of Justice (the "DOJ") has announced at least four multimillion-dollar settlements with hospital proprietors for improperly billing outpatient observation admissions as inpatient admissions. This enhanced scrutiny of improper hospital billing also has been driven by CMS, which recently expanded its use of Recovery Audit Contractors or "RACs," who are paid a contingency fee to identify improper Medicare billings by hospitals.

O. CHS's Improper Admissions Practices Significantly Inflated its Revenues

177. CHS billed Medicare for excess sums by deceptively driving up inpatient admissions at its facilities. Tenet claimed that CHS receives on average $3,500, more per patient admitted on an

inpatient basis than for patients admitted on an outpatient observation basis.

178. Tenet's expert estimated that as a direct result of CHS's improper practices, CHS improperly billed Medicare and received up to $306 million during 2006-2009, and up to $345 million during 2003-2009.

179. CHS's windfall from Medicare payments likely represents only one component of the total benefits that CHS has received through billing for unnecessary services. In 2010, CHS received only 27.2 percent of its revenue from Medicare. Upon information and belief, CHS's improper admission guidelines have also resulted in the billing of private payers and state Medicare and Medicaid programs for unnecessary inpatient admissions.

P. CHS's Admission Rates Steadily Decline After It Discontinues Use Of The Blue Book

180. After Tenet exposed CHS's practice of improperly driving up admissions and overbilling Medicare, the Company acknowledged that it had decided to discontinue using the Blue Book and move to InterQual.

181. Over the next several quarters, as CHS further reduced and ceased using the Blue Book's criteria, CHS's reported observation rates increased while its admission rates and "one-day stays" substantially decreased. Specifically, the rate of same-store inpatient admissions substantially decreased by 3.4% in Ql 2011; by 5.6% in 2Q 2011; by 7.0% in 3Q 2011, and by 6.7% in 4Q 2011. For the full year 2011, the decline in the rate of inpatient

admissions more than doubled to 5.6% from 2.5% in 2010.

182. On October 27, 2011, during CHS's 3Q 2011 earnings call, CEO Smith and CFO Cash acknowledged that "soft inpatient volumes continued in the third quarter" and attributed the 7.0% admissions decline in part to "[r]eduction in one day medical admissions," noting that "chest pain admissions accounted for 40% of the decline."

183. When questioned about the impact of switching InterQual, CEO Smith acknowledged that "[s]ome of this, by the way, you when you break it down has to do with just the movement from inpatient to outpatient." On the same call, CFO Cash acknowledged an admissions "drop throughout the company" with ER admissions a "little higher percentage."

Q. Additional Facts Supporting a Strong Inference of Scienter

184. Numerous facts support a strong inference that CHS and its senior executives Smith and Cash knew or recklessly disregarded that their public statements to investors were materially false and misleading. First, Smith and Cash emphasized that standardizing and centralizing CHS operations initiatives "encompass nearly every aspect of our business" and were "a key element in improving our operating results." CHS highlighted in its SEC filings that each hospital management team is "supported by our centralized, operational, reimbursement, regulatory and compliance expertise, as well as by our senior management

team, which has an average of over 25 years of experience in the healthcare industry."

185. CHS's top-down approach to implementing its operations initiatives included training programs for all senior hospital management, chief nursing officers, quality directors, physicians, case managers and other clinical staff. As CEO Smith boasted in CHS's 2010 earnings release, that, "we can provide the experienced operating expertise with a proven track record... in each of the communities we serve."

186. Second, since patient admissions, particularly in the ER, were a primary driver of the Company's revenues, senior management were intimately involved in crafting and monitoring these Company-wide practices which were critical to CHS's successful business model. CHS emphasized in its Form 10-Ks and other public statements that because 55% to 60% of hospital admissions originated in the ER, "we systematically take steps to increase patient flow in our ER as a means of optimizing utilization rates for our hospitals." These steps included (1) the Blue Book's unique non-industry admissions justifications criteria; (2) programming the Pro-MED system used in all ERs to prompt medically unnecessary testing in order to raise acuity levels to justify patient admissions and (3) the use of incentive programs and quotas to achieve higher admissions levels.

187. CHS's ER admission performance was monitored at the Division and Board levels. In its Form 10-Ks, CHS represented that it paid particular attention to case management issues such as patient treatment, patient length of stay and utilization of resources. Witnesses also confirm senior

management's oversight and direction through the Revenue Committee which held regular weekly meetings with CHS executives and administrators to discuss topics such as (1) implementation of the Blue Book and Pro-MED, (2) whether ED admission targets were being met, (3) whether observation rates could be lowered, and (4) whether CHS hospitals were staying under their respective Medicare and self-pay length-of-stay goals. These meetings evidence CHS's corporate culture of increasing admissions at all costs.

188. Cash's participation at these Revenue Committee meetings and discussions with former employees, support an inference that he directed and/or approved the improper admission strategies. For example, CW #1 stated that Cash occasionally attended the Revenue Committee meetings where the Blue Book and Pro-MED were discussed, and, on at least one occasion, Cash asked her how CHS could program Pro-MED to convert "level 2s" to "level 4s" in order to increase the "census", *i.e.*, admissions at specific CHS hospitals. CW #1 also stated senior management "saw a way to make money and took it to Wayne Smith for approval." These allegations support a strong inference that CHS's scheme was orchestrated at the highest levels of the Company.

189. The fact that employees, such as CW #1, were directed by superiors to modify Pro-MED to prompt testing which lacked medical necessity in order to raise patient acuity levels, and to avoid detection, is strong evidence that senior management knew that these strategies were improper and intended to conceal them.

190. Further, the fact that Smith and Cash directed and/or approved of programming Pro-MED to prompt testing that was medically unnecessary, so as to drive up patient acuity levels, in order to justify patient admissions rather than observations status, supports a strong inference of knowledge or recklessness in failing to disclose these key facts when touting the successful use of Pro-MED to increase ER admission levels, particularly in newly acquired hospitals such as Triad.

191. Further, as described above, witnesses confirmed that Carolyn Lipp, a senior CHS executive who was responsible for overseeing the development, implementation and use of the Blue Book at CHS hospitals, reported directly to Smith, and in that capacity, attended regular meetings with Smith on the topic of the Blue Book. Given the importance of ER admissions to CHS's financial success and that Medicare and Medicaid funded a large percentage of those admissions based upon the Blue Book's criteria, a strong inference can be drawn that the aggressive non-standard criteria used to justify those admissions standards were being promoted at the highest corporate levels. It is simply implausible, therefore, that Smith and Cash were unaware that the Blue Book was being used at CHS's hospitals to drive inappropriate admissions when he and Cash made numerous public statements touting CHS business strategies and performance, including the successful integration and synergies achieved at newly acquired hospitals through improved ER operations.

192. A strong inference can be drawn that defendants Smith and Cash knew of CHS's improper

admissions criteria for years given that the Blue Book was designed to ensure that the Company could overbill Medicare for medical services which, in turn, inflated CHS's revenues. Because Medicare services were one of the Company's chief sources of income, knowledge of Medicare's regulations was intrinsic to CHS's business model. Accordingly, there is a strong inference that Defendants knew or recklessly disregarded the fact that CHS's consistent growth and successful financial performance, purported "synergies" and "operating efficiencies" (as detailed in Section J, *infra*), were largely predicated on improper admissions practices that violated Medicare's rules.

193. Defendants Smith's and Cash's statements show that they knew or recklessly disregarded that CHS engaged in improperly aggressive admissions practices leading to an abundance of one-day stays. During CHS's Q2 2008 earnings call, Defendant Cash stated: "[O]ne thing's happened as we had pretty good growth with ER admissions which generally are a little bit less acuity business. So while we've got very good admissions growth, it is a little bit less acuity." Smith then stated:

> *One of the things that's maybe driving some of our volume is that we've had an – we've been working hard on these emergency rooms, and increased our emergency room admissions of over 3%, and we are getting a little less acuity in terms of those, and that would be expected when you start really pushing them and working to improve your emergency services.*

(Emphasis added).

194. Thus, Defendants acknowledged that CHS was driving up its admission rates for lower acuity patients - precisely those patients who are likely to be discharged in a day and in many instances should not have been admitted as inpatients in the first place.

195. When CHS's conduct was exposed by Tenet at the end of Class Period, the Individual Defendants attempted to temper the market's response by making false and misleading statements which included contradicting their prior representations. For example while acknowledging during a May 2, 2011 Deutsche Bank Healthcare Conference call that CHS had recently decided to move from the Blue Book to InterQual, Cash denied that there were significant distinctions between the Blue Book and InterQual, but rather claimed InterQual was "fairly close to our current Blue Book criteria". Cash asserted during the same call that he did not believe that "rapid changes" would need to be done as CHS transitioned to InterQual, because, as CHS asserted during an April 28, 2011 conference, the Blue Book was based on "current clinical practice."

196. However, Defendants' statement regarding the similarities between, and ease of transition from, the Blue Book to InterQual, is belied by the comparative analysis of the two systems initially performed by Tenet, as set forth in ¶¶160-162, and by the steady decline in "same-store inpatient admission" experienced by CHS hospitals once they switched to InterQual's admission criteria, as set forth in ¶¶180-183. Indeed Cash acknowledged during an April 28, 2011 conference call that as a

result of CHS moving from the Blue Book to InterQual, "we're seeing some [financial] effect now".

197. Accordingly, the foregoing facts support a strong inference that Smith and Cash knew or recklessly disregarded that the higher admission rates during the Class Period were due to the Company-wide use of the Blue Book's improper admissions justifications.

198. Similarly, during a April 28, 2011 conference call, in an obvious attempt to discredit the claims made by Tenet and temper the market, CHS denied that Pro-MED was used as a tool to increase admissions:

> ... [T]he system does not contain admission or observation criteria from any source. This system does not order tests. This system does not make any recommendation to physicians to admit patients, place patients in observation or discharge patients...

199. Likewise, during a Bank of America Merrill Lynch Health Care Conference on May 10, 2011, Cash claimed that Pro-MED "doesn't change [sic] to admit or put into observation or anything of that nature. It's simply a tracking system."

200. Defendants took precisely the opposite position CHS took during the Class Period. For example, Smith represented at the J.P. Morgan Healthcare Conference on January 13, 2009, that "our admission rate is up about 4% in our emergency rooms" due to the installation of the Pro-MED system in the ER at Triad hospitals. Similarly, Smith emphasized that Pro-MED has not only "improve[d] the level of service, but improv[ed] the

level of number of admissions that come through our emergency department" (Lehman Brothers Global HealthCare Conference March 18, 2008); and that through Pro-MED, "we beg[in] to see increases in terms of admissions rates through, particularly the Triad facilities, similar to what we had in the legacy CHS facilities." (Credit Suisse Health Care Conference Nov. 12, 2008).

201. CHS also made several communications to selected analysts and investors in an attempt to prop up CHS's fallen market price in response to Tenet's revelations. This conduct violated Regulation FD which requires that issuers immediately make fair disclosure to the public of any material information that it has intentionally disclosed to only a select group.[7]

202. Specifically, CHS's management held private discussions with selected investors and securities analysts in which CHS management shared material nonpublic information regarding the issues raised in the Tenet Litigation. For example:

a. A Susquehanna analyst report dated April 13, 2011 refers to "a quick check with [CHS] management yesterday afternoon," during

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[7] Regulation FD provides that "[w]henever an issuer, or any person acting on its behalf, discloses any material nonpublic information regarding that issuer, or any person acting on its behalf, discloses any material nonpublic information regarding that issuer or its securities to [one group of investors], the issuer shall make public disclosure of that information ...[s]imultanously, in the case of an intentional disclosure; and [p]romptly, in the case of a non-intentional disclosure." 17 C.F.R. § 243.l00(a).

which the analyst learned detailed, material information about CHS's operations. Specifically, CHS management purportedly shared figures relating to one-day stays and represented that "there are no arrangements provided by [CHS] facilities."

b. A Susquehanna analyst report dated April 12, 2011 refers several times to a "conversation last night" with CHS. Specifically, CHS management provided "an alternative case that could be consistent with the lower level of observations combined with normal inpatient admissions being in line with its industry peers."

c. A Wells Fargo analyst report dated April 11, 2011 refers to "key takeaways"- learned directly from a conversation "[l]ate Monday afternoon" the analyst had with Larry Cash, convened when "management reached out to a number of investors and sell-side analysts"-about (i) CHS's planned conversion away from the Blue Book and InterQual and (ii) CHS's ED admission rate.

d. Private, conversations also were referenced in the Oppenheimer analyst report dated April 13, 2011 and the UBS analyst report dated April 13, 2011.

e. These and other analyst reports observe that CHS management shared preliminary thoughts on the *Tenet Litigation* with select investors and analysts, before sharing the same information with the market generally. For example, Susquehanna's April 12th

report states: "[CHS] offered some preliminary thoughts in a conversation last night and promised to provide a more complete rebuttal within the next week."

203. CHS's senior management's private conversations with analysts and investors are further evidence of their willingness to break SEC disclosure rules in order to influence CHS's market price.

204. Finally, only after Tenet exposed CHS's improper practices, did the Company belatedly disclose numerous government investigations, lawsuits and shareholder inquiries relating to these same admission and billing practices. These events included:

(1) the receipt of a subpoena on March 31, 2011 from the U.S. Department of Health and Human Services and OIG, "in connection with an investigation of possible improper claims submitted to Medicare and Medicaid";

(2) an investigation commenced by the Office of the Attorney General of the State of Texas on November 15, 2010 concerning the ED procedures and billing for CHS's 18 Texas hospitals which accounted for 15% of the Company's revenues;

(3) the November 2010 receipt of a letter from a shareholder group CtW Investment Group, alerting CHS of issues similar to allegations in the *Tenet Litigation*; and

(4) contact by the DOJ regarding a whistleblower complaint concerning

improper Medicare billing which was unsealed in December 2010.

205. The foregoing facts support a strong inference that Defendants' failure to disclose: (1) CHS's improper admissions practices; (2) CHS's manipulated admission rates; and (3) the effect of that manipulation on CHS's financial performance, was knowing or in reckless disregard of the truth.

206. CHS's knowledge is also attributable through other executive including Plattner, Carlton and Newsome, as described herein. In September 2008, Newsome, who held senior management positions at CHS as the President of both Division II and, later, Division III, left CHS to become the Chief Executive Officer of Health Management Associates, Inc. ("HMA"). CHS and HMA are now both targets of government investigations and defendants in civil litigation alleging they were engaged in similar admissions misconduct that overbilled Medicare. This is a function of their common leadership through Newsome, who held a top management position at CHS, and reported directly Smith and Cash, as well as the Board, through September 2008. These facts support an inference of scienter at the highest levels at CHS.

207. Under Newsome's leadership, HMA has been the subject of at least two lawsuits concerning HMA's improper patient admissions practices and/or the failure to disclose such practices to investors. First, a retired agent for the Federal Bureau of Investigation, who worked at HMA as the Director of Compliance and has 30 years of experience investigating Medicare fraud as a supervisor of healthcare fraud unit in Miami, filed a whistleblower

suit on October 21, 2011 against HMA[8] pursuant to in Florida's Private Sector Whistle Blower's Act, alleging that HMA terminated his employment for uncovering widespread fraudulent billing of Medicare, specifically that HMA was inappropriately admitting patients, rather than placing them in observation, "who clearly did not meet the standards for inpatient admission." Second, in a suit alleging substantial similar allegations to those alleged by Lead Plaintiff herein, HMA and Newsome were sued in the U.S. District Court for the Middle District of Florida on February 2, 2012,[9] where the plaintiff alleged HMA, which also used Pro-MED and Newsome violated federal securities laws by failing to disclose HMA's improper admissions and fraudulent Medicare billing practices relating to improper admissions practices.

Insider Trading

208. Additional evidence of scienter is shown through the Individual Defendants' personal stock sales. Smith and Cash sold substantial amounts of their CHS shareholdings before and during the Class Period, while in possession of material information about CHS's scheme to boost its hospital admissions that gave a misleading picture of the Company's operations, synergies, and successful financing performance. In total, Smith and Cash reaped a total of approximately $33,840,061 in proceeds from

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[8] *Meyer v. Health Mgmt. Associates, Inc.*, Case No. 11-25334 (17th Jud. Dist. Broward County, Fla.).

[9] *Norfolk County Retirement Sys. v. Health Management Associates, Inc.*, 12-cv-0228 (M.D. Fla.).

Class Period sales, as indicated on the tables at ¶¶48 and 50, *supra*.

R. Defendants' Additional Material Misstatements And Omissions During The Class Period

209. During the Class Period, CHS and senior executives Smith and Cash made numerous materially false and/or misleading statements about CHS's operating efficiencies, growth strategies and admissions gains. What Defendants failed to disclose was that for more than a decade, CHS had engaged in a systematic scheme to improperly boost its inpatient admissions through the use and implementation of, *inter alia*, the Blue Book, Pro-MED and company incentives and quotas at CHS's existing facilities and newly acquired hospitals. These practices had the consequence of improperly increasing CHS's Medicare reimbursement revenues, by admitting patients who required outpatient observation only. CHS failed to disclose this information even after various government agencies had commenced investigations and at least one shareholder group notified CHS of substantially similar allegations as those contained in this Complaint.

Second Quarter 2006

210. On July 26, 2006, CHS issued a release announcing its financial results for the second quarter ended June 30, 2006 (the "Q2 2006 Earnings Release"). The Company reported net operating revenues of $1.061 billion, a 15.5 percent increase compared to $918.7 million for the same period of the

prior year. The Company further reported a net income of $52.4 million, or $0.54 diluted earnings per share for the quarter, compared to $40.5 million, or $0.43 diluted earnings per share in the same period of the prior year. CHS also reported, on a same-store basis, admissions growth of 1.1% and adjusted admissions growth of 0.5%, when compared to the same *period of the prior year*.

211. *Commenting on the results, CEO Smith stated: "[CHS] delivered another very strong financial and operating performance for the second quarter of 2006. These results reflect consistent execution of our centralized and standardized operating strategy, the successful integration of recently acquired hospitals and our continued focus on quality care."* (Emphasis added).

212. CEO Smith also addressed CHS's acquisition of several hospitals during the quarter:

> Our acquisition pace has been exceptionally strong through the first half of 2006. As we have continued to acquire new facilities and assimilate them into our system, *we have realized greater operating efficiencies while improving volumes and revenues*. At the same time, we have created an opportunity to capture healthcare services that were previously sent out of the local market. *Our proven ability to deliver improved results* and foster positive community relations has continued to be a distinct competitive advantage for Community Health Systems. We will continue to look for opportunities to selectively acquire new hospitals.

(Emphasis added).

213. The foregoing representations in ¶¶211-212, *supra*, were materially false and misleading because CHS failed to disclose that its success in executing its centralized and standardized operating strategy, its success as an acquirer, its operational performance and its operating efficiencies were dependent in large part upon CHS's undisclosed and unsustainable admissions practices, as discussed in detail above.

214. On July 28, 2006, the Company filed its quarterly report for the second quarter with the SEC on a Form 10-Q, which was signed by Smith and Cash (the "Q2 2006 Form 10-Q"). The Q2 2006 Form 10-Q reiterated the previously announced financial results. In addition, pursuant to the Sarbanes-Oxley Act of 2002 ("SOX"), the Q2 2006 Form 10-Q included certifications by Smith and Cash, stating that the Q2 2006 Form 10-Q "d[id] not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made... not misleading..."

215. On July 27, 2006 CHS held a Q2 earnings conference call. On the call, Smith engaged in this question and answer:

> Q: ... . Your all's experience, are you guys doing anything now to improve these hospitals than you have done differently? Is there anything you're working on as a first priority with doctors or services that may be helping to enhance some of these things? It just seems like it has picked up a little bit more in the last couple of years.

> A: Wayne Smith: Yes, our model really has not changed, and our methodology really has not changed all that much in terms of the way we look at new facilities. We work hard on the expense side the first year and try to figure out everything we can to improve the expenses, and everything from staffing to getting them in – our standard – *all of these things we standardize and centralize* and start working on our plan for recruiting physicians and develop a plan in terms of physician need. That works.
>
> That has been working pretty well for us, so we really have not changed anything dramatically. We might be getting a little better at doing that. We've done it now so many times. We bought about 50 facilities over the last nine or 10 years. But surely we are beginning to perfect that a little bit. *But having said that, no, there is no new silver bullets that we have. It is just the basic blocking and tackling over and over again.*

(Emphasis added).

216. The foregoing representations in ¶¶214-215, were materially false and misleading because CHS failed to disclose that its financial growth and inpatient admissions were driven in large part by CHS's implementation of the improper strategies as detailed above, in order to improperly increase overall hospital inpatient admissions. Further, these statements were materially false and/or misleading because CHS failed to disclose that its success through acquisitions was in large part dependent upon CHS's implementation of its admissions practices at these newly acquired hospitals to navigate patients into inpatient treatment despite

the absence of a clinical basis for these patients to be admitted into the hospital.

Third Quarter 2006

217. On October 25, 2006, CHS issued a release announcing its financial results for the third quarter ended September 30, 2006 (the "Q3 2006 Earnings Release"). CHS reported net operating revenues of $1.123 billion, a 20.9 percent increase compared to $929.3 million for the same period of the prior year. The Company further reported a net income of $48.2 million, or $0.51 diluted earnings per share for the quarter, compared to $42.9 million, or $0.46 diluted earnings per share for the same period of the prior year. CHS also reported a 16.9% increase in total inpatient admissions and a 2.6% increase in same-store admissions compared to the same period of the prior year.

218. Commenting on the results, CEO Smith stated:

> Community Health Systems continued to demonstrate solid execution in a challenging environment during the third quarter of 2006. *The year-over-year gain in revenues and higher patient volumes on a same-store basis reflect the benefits of our proven centralized operating strategy and the assimilation of recently acquired hospitals.* We have continued to pursue our growth strategy through a combination of market share opportunities and acquisitions. Since the beginning of 2006, we have acquired new hospitals at an aggressive pace with six new hospitals added to our portfolio. We believe Community Health Systems has a strong base of

> assets with opportunities for additional growth, and we remain very enthusiastic about our prospects for the remainder of 2006.

(Emphasis added).

219. On October 27, 2006, the Company filed its quarterly report for the third quarter and nine months ended September 30, 2006 with the SEC on a Form 10-Q, which was signed by CEO Smith and CFO Cash (the "Q3 2006 Form 10-Q"). The Q3 2006 Form 10-Q reiterated the previously announced financial statements and further stated:

> Our financial results for the three and nine months ended September 30, 2006, *reflect our continued growth in volumes and revenues and reflect our capacity to improve the level and scope of services and ... our ability to improve operating efficiencies.*

(Emphasis added).

220. On October 26, 2006 CHS held a Q3 2006 earnings conference call. On the call, CEO Smith touted CHS's performance:

> Community Health Systems continues to demonstrate *solid execution* in this *challenging environment* during the third quarter 2006. Same-store year-over- year gain in patient volume and revenue and cost management reflect our *centralized operating platform and successful integration of our acquired hospitals*.

(Emphasis added).

221. The foregoing representations in ¶¶217-220, *supra*, were materially false and misleading because CHS failed to disclose that its "centralized operating

platform" and gains in ER inpatient rates, improved operating efficiencies, and the successful integrations of its newly acquired hospitals were driven in large part by CHS's implementation of the improper strategies as detailed above, in order to increase hospital inpatient admissions by utilizing an improper and unsustainable strategy.

Fourth Quarter and Full Year 2006

222. CFO Cash, speaking at a Credit Suisse Boston Healthcare Conference on November 15, 2006 about CHS's ER growth opportunities stated as follows:

> The second big strategy was the ER. *We came in the company in 1997, we had about 2% to 11% of the ER visit became and inpatient as a result to adding specialists and adding services and a better management [sic]. We now get about 14% to 15%.* With a standard marketing program in all our markets, there is still one marketing program we think just on the hospital side you see your results from. *Each hospital has a – Promed system in all our hospitals to let us arrange the endocrine management and also make sure all are covered, services are rendered.*

(Emphasis added).

223. The foregoing representation was materially false and misleading because Defendant Cash failed to disclose that CHS's dramatic ED admissions increase was attributable in large part to CHS implementing its improper and unsustainable operating strategies, as detailed above, that were designed to drive patients into short, one-day stay inpatient treatment despite the lack of a medical

basis for these patients to be admitted into the hospital.

224. On February 15, 2007, the Company issued a release announcing its financial results for the fourth quarter ended December 31, 2006 (the "Q4 2006 Earnings Release"). The Company reported net operating revenues of $1.154 billion, a 17.6 percent increase compared to $982.1 million for the same period of the prior year. The Company further reported a net income of $53.6 million, or $0.57 diluted earnings per share for the quarter, compared to $48.1 million, or $0.51 diluted earnings per share in the same period of the prior year. CHS also reported a 15.7% increase in total admissions and a 3.2% gain in same-store admissions compared to the same period of the prior year.

225. CEO Smith commenting on the results, stated:

> Our fourth quarter performance marked a solid finish to another good year for Community Health Systems. We posted record revenues of $4.4 billion in 2006, a 17 percent gain over the prior year, reflecting strong volume growth across our network of hospitals throughout the country. Our same store growth metrics are another important measure of our success in 2006 and *these favorable trends demonstrate consistent execution of our operating strategy*.

(Emphasis added).

226. In the Q4 2006 Earnings Release, CEO Smith continued:

> We further extended our market reach in 2006 with the acquisition of eight hospitals.

> *Community Health Systems has continued to pursue an aggressive acquisition strategy with a proven track record for finding suitable hospitals and successfully assimilating these facilities into our system.*

(Emphasis added).

227. On February 20, 2007, the Company filed its 2006 annual report on Form 10-K, which was signed by Smith and Cash (the "2006 Form 10-K"). The 2006 Form 10-K reiterated the previously released financial statements. In addition, pursuant to SOX, the 2006 Form 10-K included certifications by Smith and Cash, stating that the 2006 Form 10-K "d[id] not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made ... not misleading ..."

228. The 2006 Form 10-K addressed, *inter alia*, CHS' "Business Strategy" to "Increase Revenue at [CHS] Facilities", including "Emergency Room Initiatives":

> *Given that over 60% of our hospital admissions originate in the emergency room, we systematically take steps to increase patient flow in our emergency rooms as a means of optimizing utilization rates for our hospitals. ...*
>
> *One component of upgrading our emergency rooms is the implementation of specialized computer software programs designed to assist physicians in making diagnoses and determining treatments. The software also benefits patients and hospital personnel by assisting in proper documentation of patient records and tracking patient flow.* It enables our nurses to provide

> more consistent patient care and provides clear instructions to patients at time of discharge to help them better understand their treatments.

(Emphasis added).

229. The foregoing representations in ¶¶224-228, *supra*, were materially false and misleading because CHS failed to disclose that its "proven track record" and gains in ER inpatient rates and improved operating efficiencies were driven in part by its implementation of the Blue Book at CHS's legacy hospitals as well as its newly acquired hospitals, in order to increase hospital inpatient admissions by utilizing an improper and unsustainable operating strategy. CHS also failed to disclose that the Pro-MED software that assisted physicians in making diagnoses was rigged in such a way as to drive ED inpatient hospital admissions higher by prompting testing that was clinically unnecessary in order to raise patient acuity levels and, thereby, "justify" improper admissions.

230. The 2006 Form 10-K also addressed CHS's compliance with government regulations and standards:

> The healthcare industry is required to comply with extensive government regulation at the federal, state, and local levels. Under these regulations, hospitals must meet requirements to be certified as hospitals and qualified to participate in government programs, including the Medicare and Medicaid programs. These requirements relate to the adequacy of medical care, equipment, personnel, operating policies and procedures, maintenance of adequate

> records, hospital use, rate-setting, compliance with building codes, and environmental protection laws. There are also extensive regulations governing a hospital's participation in these government programs.... *We believe that our hospitals are in substantial compliance with current federal, state, and local regulations and standards.*

(Emphasis added).

231. CHS also included a description of its quality assurance programs in the 2006 Form 10-K:

> We have implemented various programs to ensure continuous improvement in the quality of care provided. We have developed training programs for all senior hospital management, chief nursing officers, quality directors, physicians and other clinical staff. *We share information among our hospital management to implement best practices and assist in complying with regulatory requirements....*
>
> Each of our hospitals is governed by a board of trustees, which includes members of the hospital's medical staff. *The board of trustees establishes policies concerning the hospital's medical, professional, and ethical practices, monitors these practices,* and is responsible for ensuring that these practices conform to legally required standards. *We maintain quality assurance programs to support and monitor quality of care standard and to meet Medicare and Medicaid accreditation and regulatory requirements.* Patient care evaluations and other

> quality of care assessment activities are reviewed and monitored continuously.

(Emphasis added).

232. In the 2006 Form 10-K, CHS explained that it continually monitored and updated its compliance programs:

> Since its initial adoption, *the compliance program continues to be expanded and developed to meet the industry's expectations and our needs*. Specific written policies, procedures, training and educational materials and programs, as well as auditing and monitoring activities have been prepared and implemented to address the functional and operational aspects of our business. Included within these functional areas are materials and activities for business sub-units, including laboratory, radiology, pharmacy, emergency, surgery, observation, home health, skilled nursing, and clinics. *Specific areas identified through regulatory interpretation and enforcement activities have also been addressed in our program*. Claims preparation and submission, including coding, *billing, and cost reports, comprise the bulk of these areas*.

(Emphasis added).

233. In the 2006 Form 10-K, the Company reported that it had an ethics and compliance program, which includes a Code of Conduct. The Company's Code of Conduct addresses coding and billing, and states in relevant part:

> Third Party Payers

> Coding and Billing
>
> All individuals responsible for coding and billing for services will adhere to all official coding and billing guidelines, rules, regulations, statutes, and laws. *Colleagues are prohibited from knowingly causing or permitting false or fraudulent claims. Furthermore, colleagues shall not engage in any intentional deception or misrepresentation intended to influence any entitlement or payment under any federal health care benefit program*.

CHS Code of Conduct, *available at* http://www.chs.net/company_overview/code_conduct.html (Emphasis added).

234. The foregoing representations in ¶¶230-233, were materially false and misleading because CHS failed to disclose the Company's pervasive practice of intentionally increasing the number of inpatient admissions even when such treatment was not clinically necessary for the purpose of triggering higher reimbursement amounts from Medicare and insurance companies. Furthermore, the Company's systematic violations of Medicare rules, as detailed herein, belied its repeated representations that it was in compliance with federal regulations governing the provision of medical care. Defendants made substantially similar misstatements and omissions during the Class Period as those contained in ¶¶228, 230-233, in their 2007-2010 Form 10-Ks discussing CHS's "Business Strategy", "Emergency Room Initiatives" and compliance with federal regulations, including but not limited to Medicare. For the reasons discussed above, these representations were also materially false and/or misleading.

First Quarter 2007

235. On April 25, 2007, the Company issued a release announcing its financial results for the first quarter ended March 31, 2007 (the "Ql 2007 Earnings Release"). The Company reported net operating revenues of $1.204 billion, a 17.3 percent increase compared to $1.027 for the same period of the prior year. The Company further reported a net income of $54.3 million, or $0.58 diluted earnings per share for the quarter, compared to $54.0 million, or $0.55 diluted earnings per share for the same period of the prior year. CHS also reported at 12.7% increase in total admissions compared to the same period of the prior year. On a same-store basis, admissions increased 1.0% and adjusted admissions increased 1.2% compared to the same period of the prior year.

236. CEO Smith highlighted Ql 2007 results and the benefits of CHS' acquisition strategy:

> With our proven centralized operating strategy and, more importantly, disciplined cost management, we continue to manage successfully through the issues facing the industry.
>
> * * * *
>
> Our track record of assimilating new hospitals into our system with favorable results demonstrates one of the company's strengths. We are also very focused on implementing a successful integration of the Triad hospitals.

237. On April 26, 2007, the Company filed with the SEC its report on Form 10-Q for the first quarter of 2007, which was signed by CEO Smith and CFO

Cash (the "Q1 2007 Form 10-Q"). The Ql 2007 Form 10-Q "Management's Discussion and Analysis of Financial Condition and Results of Operations" highlighted CHS' admission growth:

> On a consolidated basis, total admissions increased 12.7% during the three months ended March 31, 2007 compared to the three months ended March 31, 2006. Admissions at hospitals owned throughout both periods increased 1.0% during the three months ended March 31, 2007, as compared to the same period in the prior year .... *The increase in admissions continue to reflect the application of our operating strategies of growing through selective acquisitions and improving same-store hospital performance.*

(Emphasis added).

238. The foregoing representations in ¶¶235-237, *supra*, were materially false and misleading because CHS failed to disclose that its financial growth and inpatient admissions gains were driven, in part, by CHS's implementation of the Blue Book and programming Pro-MED to generate tests and procedures in the ER that were not clinically necessary, as detailed above, in order to increase overall hospital inpatient admissions at its newly acquired hospitals and CHS legacy hospitals. Further, these statements were materially false and misleading because CHS failed to disclose that "one of the company's strengths," the assimilation of CHS's newly acquired hospitals, was driven in large part by CHS's implementation of its admissions practices at these newly acquired hospitals, designed to admit patients into the hospital despite the

absence of a clinical basis for these patients to be admitted into the hospital.

Second Quarter 2007

239. On July 30, 2007, the Company issued a release announcing its financial results for the second quarter ended June 30, 2007 (the "Q2 2007 Earnings Release"). The Company reported net operating revenues of $1.249 billion, a 17.7 percent increase compared to $1.061 billion for the same period of the prior year. The Company further reported a net income of $53.8 million, or $0.57 diluted earnings per share for the quarter, compared to $52.4 million, or $0.54 diluted earnings per share for the same period of the prior year. CHS also reported a 10.9% increase in total admissions compared to the same period of the prior year. On a same-store basis, admissions decreased 0.2% and adjusted admissions decreased 0.4% compared to the same period of the prior year.

240. CEO Smith touted these results in the Q2 2007 Earnings Release:

> Community Health Systems delivered a solid financial and operating performance for the second quarter of 2007. These results reflect consistent execution of our centralized and standardized operating strategy and our ongoing focus on quality care. This strategy has enabled us to continue to be successful in meeting our objectives in a challenging, constantly evolving healthcare environment.

* * * *

> We are very excited about our ability to further expand our reach and geographic scope and look forward to the successful integration of the Triad operations.

241. On July 31, 2007, the Company filed its quarterly report for the second quarter with the SEC on a Form 10-Q, which was signed by Smith and Cash (the "Q2 2007 Form 10-Q"). In the Q2 2007 Form 10-Q CHS stated:

> The increase in our consolidated admissions reflects *our strategy of growing through selective acquisitions*. The flat trend in same-store admissions reflects our targeted closure of certain unprofitable service offerings in specific markets and a general trend in the industry during the current period. Furthermore, although we have experienced an increase in bad debts related to self-pay business and an increase in salaries and benefits related to additional employed physicians and incremental stock based compensation, *we believe that our consolidated financial results reflect our strategy and ability to increase revenue* and effectively manage costs while facing difficult industry related issues such as increasing numbers of uninsured and underinsured patients.

(Emphasis Added).

242. On July 31, 2007 CHS held a Q2 2007 earnings conference call. On the conference call, CEO Smith discussed potential growth opportunities through the recently announced Triad acquisition:

> We have spent a long period of time, trying to perfect our work in our emergency rooms as it

> relates to emergency room admissions. We have done a lot of good work with that. We have a lot of good systems in place. We talked about [Pro] Med all the time when we're out publicly. Triad does not have any systems and they have not done any analytical work in terms of their emergency services. *And actually their admission rate is lower than ours, which historically you would think would be higher, because generally speaking, they may have hospitals that have a larger number of specialists.*

(Emphasis added).

243. The foregoing representations in ¶¶239-242, *supra*, were materially false and misleading because CHS failed to disclose that its financial growth, its growth through selective acquisitions and its inpatient admissions gains were driven in part by CHS's implementation of the Blue Book and programming Pro-MED to generate tests and procedures in the ER that were not clinically necessary, as detailed above, in order to increase overall hospital inpatient admissions. CHS also failed to disclose the reasons why its ED results were higher than Triads, *i.e.*, as a result of CHS's ED admissions practices which were designed to place patients into inpatient treatment without a clinical basis for doing so. Further, CHS also failed to disclose that the planned "successful integration" of Triad would result from CHS's implementation of its admissions practices at the former Triad hospitals.

Third Quarter 2007

244. On October 30, 2007, the Company issued a release announcing its financial results for the third quarter ended September 30, 2007 (the "Q3 2007 Earnings Release"). The Company reported net operating revenues of $2.352 billion, a 110.4 percent increase compared to $1.118 billion for the same period of the prior year. The Company further reported a net income of $10.5 million, or $0.11 diluted earnings per share for the quarter, compared to $8.2 million, or $0.09 diluted earnings per share for the same period of the prior year.

245. In the Q3 2007 Earnings Release CEO Smith highlighted third quarter results:

> These results include the operations of Triad since the completion of the Triad acquisition on July 25, 2007. While we are pleased with the progress made in just a few short months, there is much left to be accomplished and our management team continues to work diligently to integrate the Triad hospital operations. I strongly believe that this will be a winning transaction for our shareholders.
>
> * * * *
>
> Community Health Systems has a *proven track record for finding suitable hospitals and successfully assimilating these facilities into our system*. With the completion of the Triad acquisition, we have significantly enhanced the scope of our operations and geographic diversity. We remain focused on the key areas for success in our business – an *effective centralized and standardized operating platform*, effective cost

> management, a successful physician recruitment program and a favorable reputation in the marketplace – as we continue to move Community Health Systems forward into 2008.

(Emphasis added).

246. On November 2, 2007, the Company filed its quarterly report for the third quarter with the SEC on a Form 10-Q, which was signed by Smith and Cash (the "Q3 2007 Form 10-Q"). The Q3 2007 Form 10-Q "Management's Discussion and Analysis of Financial Condition and Results of Operations" discussed CHS's acquisition of Triad completed in July 2007:

> We believe the acquisition of Triad will benefit the Company since it expanded the number of markets we serve, expanded our operations into five states where we previously did not operate, and reduced our concentration of credit risk in any one state. We also believe that synergies obtained from eliminating duplicate corporate functions and centralizing many support functions will allow us to improve Triad's margins.

247. On October 31, 2007 CHS held a Q3 2007 earnings conference call. On the call, Cash and Smith discussed synergies and the Triad acquisition:

> [Cash]: ...And as Wayne pointed out, we've achieved approximately 12% of our targeted first-year synergies, more importantly our 2008 calendar year does include 150 million of synergies in addition to the normal growth that's expected to occur. And Wayne will now provide a brief recap.

> [Smith]: ...Well, we were pleased with the progress made with our integration of Triad in just a few months. There is still much left to accomplish; and our management teams continue to work diligently to integrate these assets. But we're definitely on the right track ...

248. The foregoing representations in ¶¶244-247, *supra*, were materially false and misleading because CHS failed to disclose that the expected synergies in the Triad acquisition would be driven in large part by CHS's implementation of the improper and unsustainable operating strategies that had not been previously employed at the former Triad hospitals, including the Blue Book and programming Pro-MED to generate tests and procedures in the ER that were not clinically necessary in order to raise acuity levels, as detailed above, in order to increase overall hospital inpatient admissions.

Fourth Quarter and Full Year 2007

249. On November 13, 2007, CEO Smith, speaking at a Credit Suisse China Healthcare Conference, discussed the integration of Triad hospitals through CHS's "standardized, centralized" business strategy:

> Historically, what we've done and what we will do with the Triad facilities is what we've done in the past in terms of – and which is a very simple straightforward business strategy in terms of recruiting physicians and expanding services and *increasing emergency room services*, and improving hospital operations. *We've done this very successfully over the last number of years. I think probably we have the best track record in*

> *the industry in terms of earnings growth.* So we don't see any reason why we can't continue to do that with these new facilities....
>
> The other area that we found opportunity in historically for our hospitals has been our emergency services, and we work on our emergency services in terms of *standardizing and centralizing our approach*.

250. The foregoing representation was materially false and misleading because CHS failed to disclose that, since CEO Smith and CFO Cash arrived at CHS, the increased levels of patients admissions at CHS hospitals were the product of CHS's improper admissions practices, discussed in detail above, to steer patients into inpatient treatment despite the absence of a clinical basis for these patients to be admitted into the hospital. Specifically, CHS failed to disclose that CHS had engaged in an effort to increase its patient admissions through the implementation of the improper admission practices that resulted in the admission of patients into CHS hospitals who should have been treated in observation. CHS's reputation and track record for consistent earnings and revenue growth were based on this same improper conduct.

251. On February 21, 2008, the Company issued a release announcing its financial results for the fourth quarter ended December 31, 2007 (the "Q4 2007 Earnings Release"). The Company reported net operating revenues of $2.625 billion, a 137.6% increase compared to $1.105 billion for the same period of the prior year. In the Q4 2007 Earnings Release, the Company reiterated that "[CHS] remains focused on the key areas for success in its

business — an *effective centralized and standardized operating platform*, effective cost management, a successful physician recruitment program and a favorable reputation in the marketplace." (Emphasis added).

252. In addition, CEO Smith stated:

> Our fourth quarter performance capped off a year of significant growth and progress for Community Health Systems. We reached an important milestone in 2007 with the completion of the Triad acquisition and *we have continued to focus on the integration of the Triad facilities into our portfolio of hospitals. We intend to build on our past success as a proven operator and leverage these assets to further extend our record of growth....*

(Emphasis added).

253. On February 29, 2008, the Company filed its 2007 annual report on Form 10-K, which was signed by Smith and Cash (the "2007 Form 10-K"). The Company made substantially similar statements to those stated above in ¶¶228, 230-233 in its 2007 Form 10-K filed on February 29, 2008 at pp. 2-3, 5, 12-13, 19.

254. The foregoing representations in ¶¶251-253, supra, were materially false and misleading because CHS failed to disclose that the increased level of patient admissions at CHS hospitals was due in large part to CHS's improper admissions practices, to steer patients into inpatient treatment despite the absence of a clinical basis for these patients to be admitted into the hospital, which has resulted in various regulatory investigations and the potential

for significant liability to CHS. Specifically, CHS failed to disclose that CHS had engaged in an effort to increase its patient admissions through implementation of the improper admission practices that resulted in the admission of patients into CHS hospitals who, under industry standard clinical criteria, should have been treated in observation. CHS's purported reputation as a successful operator and acquirer was based on this same improper conduct. Further, CHS's representations about the integration of Triad were materially false and misleading because CHS failed to disclose that these same improper admission practices were the main driver of growth at the newly acquired Triad hospitals.

First Quarter 2008

255. At a JP Morgan Chase & Co. Healthcare Conference on January 9, 2008, Smith touted CHS's "*standardized, centralized business processes and procedures…* [which are at] *the heart of the organization and it continues to be and is probably the main reason that we were able to get as far as we have as quickly as we have.*" Smith emphasized how important it is that "[W]e manage our emergency rooms" using *Pro-MED*. Smith noted that "*ProMED is a system that provides us not only good demographic information on the patients that come to our facilities, but also good clinical information, diagnostic information.*" The result is *"over the last 4 or 5 years*, [CHS has] *been able to increase* [its] *admission rate by about 10% in our emergency rooms* through the use of this Pro-Med system."

256. Similarly, at the Stanford Group Company Healthcare Conference held on January 17, 2008, CFO Cash represented:

> Also, if you looked at the ER process, it's a system we're going to put in place over the next year or so in most of the Triad hospitals, the Pro-MED system; *it's helped us a lot to identify admissions to emergency room [sic] and do a very good quality job*. And make sure that the appropriate care is given; so that's an activity.

(Emphasis added).

257. At the March 4, 2008 Raymond James Institutional Investors Conference Cash highlighted the improvements to CHS made in ED, stating:

> [A]lmost 60% of our admissions, legacy CHS came through the emergency room, where Triad is about 55%. We've spent probably about $140 million on 42 ER renovations. Now, you may ask why you want to do that since you get your self-paid through there. We think we get that anyway. *We came to this company about 10 years ago. The admit rate through the ER was about 10%, now it's about 15%.* Triad, who's actually got more physicians and more services, should have a higher admit rate through the ER; it's actually running about 14%. We have a standard marketing program we use. We also have a standard data tracking system. *Pro-MED is in all our hospitals, and we've put that in the Triad hospitals.*
>
> *This is an opportunity, we think, to increase the volume in both companies as we do a better job of managing the ER.* We've improved our

> satisfaction. It's been a big contributor to same-store admissions growth. *If you track the same hospitals we've owned since 2002 through 2006, we've grown our admissions by 10% coming through the ER, so it's a strength of ours to do a very good job in that area.*

258. These foregoing statements in ¶¶255-257 were materially false and misleading because Defendants failed to disclose that CHS's success was due, in large part, to the Company's undisclosed strategies, including the Blue Book's aggressive, non-industry standard admissions criteria, programming Pro-MED to generate tests and procedures in the ER that were not clinically necessary in order to raise patient acuity levels, and a quota incentive system, which had the cumulative effect of drastically increasing the number of one-day stays while decreasing the observation rate.

259. On April 29, 2008, CHS issued a release announcing its financial results for the first quarter ended March 31, 2008 (the "Ql 2008 Earnings Release"). The Company reported net operating revenues of $2.728 billion, a 136.3 percent increase compared to $1.154 billion for the same period of the prior year. The Company further reported a net income of $60.l million, or $0.63 diluted earnings per share for the quarter, compared to $54.3 million, or $0.58 diluted earnings per share for the same period of the prior year. CHS also reported a 111.1% increase in total admissions compared to the same period of the prior year, according to CHS attributable to the "expansion of our hospital portfolio in 2007." On a same-store basis, admissions

increased 3.8% compared to the same period of the prior year.

260. In the Q1 2008 Earnings Release, CEO Smith applauded the results stating:

> Community Health Systems is off to a very solid start for 2008. *Our first quarter results reflect our ability to drive revenues and improve the operating performance of both our existing and recently acquired facilities.* In addition, the favorable admission trends are due in part to a strong flu season and the additional day during the quarter period because the current year is a leap year.
>
> Our strategic focus for 2008 will be on pursuing growth opportunities within our existing markets. *As we continue our integration efforts, we are expanding our proven business model and identifying operating synergies in order to drive improved returns on the additional assets acquired in 2007. Toward that end, we remain f ocused on the key areas for success in our business – an effective centralized and standardized operating platform, disciplined cost management, a successful physician recruitment program and strategic investments to ensure we have the right equipment, technologies and clinical services for our hospitals.* We are very pleased with our progress to date and remain confident in our ability to extend our record of growth as we move Community Health Systems forward in 2008.

(Emphasis added).

261. The foregoing statements were materially false and misleading because CHS failed to disclose that its admissions numbers, ER strategy, and CHS's centralized and standardized operating platform depended in large part on CHS's improper and unsustainable admissions practices. In particular, CHS failed to disclose that its "ability to drive revenues," as well as its ability to "identify[] operating synergies," was due, in large part, to the Company's undisclosed strategies, including the Blue Book's aggressive, non-industry standard admissions criteria, programming Pro-MED to generate tests and procedures in the ER that were not clinically necessary in order to raise patient acuity levels, and a quota incentive system, which had the cumulative effect of drastically increasing the number of one-day stays while decreasing the observation rate.

262. On May 2, 2008, the Company filed its quarterly report for the first quarter with the SEC on a Form 10-Q, which was signed by CEO Smith and CFO Cash (the "Ql 2008 Form 10-Q"). CHS discussed its revenue and volume growth this way:

> For the three months ended March 31, 2008, we generated $2.728 billion in net operating revenues, a growth of 136.3% over the three months ended March 31, 2007, and $60.1 million of net income, an increase of 10.7% over the three months ended March 31, 2007. . . . *The increases in net operating revenue and volume are due in part to our acquisition of the former Triad hospitals, as well as a benefit from a strong flu season.*

(Emphasis added).

263. On April 30, 2008 CHS held a Ql 2008 conference call. On the call, CEO Smith attributed CHS' inpatient admissions growth to the increase in the flu and the extra day in February due to the leap year:

> With that, I'd like to review some of the key accomplishments for the quarter. As you know, by February influenza was widespread across the country and remained a strong admission for us throughout the second week in March. Our same-store admissions, benefitting from this strong flu benefit, for the first quarter were up 3.8%. Same-store adjusted admissions also increased 3.8% for the same quarter. Same-store net revenues increased 5.7%.

264. In the same earnings call, CFO Cash similarly stated:

> Our consolidated admissions were 177,280 in the first quarter, and the consolidated adjusted admissions were 310,251. Same-store admissions increased 3.8%, and our same-store self-pay admissions as a percent of admissions increased 20 basis points.
>
> *Flu-related admissions represent approximately 120 basis points of increase, an additional day in February representing another 120 basis points.*

(Emphasis added).

265. The foregoing representations in ¶¶262-264, *supra*, concerning CHS's same-store admissions increases due to the flu and the leap year were materially false and misleading because in addition to these industry-wide factors, same-store admissions increases were driven in part by CHS's

implementation of the Company's undisclosed strategies, including the Blue Book's aggressive, non-industry standard admissions criteria, programming Pro-MED to generate tests and procedures in the ER that were not clinically necessary in order to raise patient acuity levels, and a quota incentive system, which had the cumulative effect of drastically increasing the number of one-day stays while decreasing the observation rate. In addition, the statement in ¶262, *supra*, was materially false and misleading because CHS failed to disclose that its results after acquiring Triad were driven by CHS's implementation of its admissions practices at the former Triad hospitals, discussed in detail above, designed to drive patients into inpatient treatment despite the lack of a medical basis for these patients to be admitted into the hospital.

Second Quarter 2008

266. On July 28, 2008, CHS issued a release announcing its financial results for the second quarter ended June 30, 2008 (the "Q2 2008 Earnings Release"). The Company reported net operating revenues for the quarter of $2.691 billion, a 124.6 percent increase compared to $1.198 billion for the same period of the prior year. CHS also reported a 101.3% increase in total admissions compared to the same period of the prior year. On a same-store basis, admissions increased 2.3% and adjusted admissions increased 2.4%, compared to the same period of the prior year.

267. In the Q2 2008 Earnings Release, CEO Smith commented:

Community Health Systems delivered a solid operating performance for the second quarter of 2008. *These results reflect consistent execution of our strategy and our continued progress with respect to the integration of the significant number of facilities acquired in 2007.* We are pleased with the overall trends in our business during the second quarter with strong same-store growth metrics as well as efficient expense management. Our hospitals are well positioned in each of their respective markets, and are geographically diversified, which minimizes our operating risk as no one state represents a disproportionately greater percentage of our total revenues or earnings. *We believe we have a business model in place that has proven, over time, to enhance the operating performance at both our existing and acquired facilities. This model has enabled us to continue to meet our objectives in today's hospital industry operating environment.*

As we continue to integrate our recently acquired hospitals, we are focused on the further expansion of our business model to drive improved returns on these assets. We are pleased with our progress through this transition period and will continue to identify operating synergies including reduced marketing and supply costs, targeted physician recruiting, centralized managed care negotiations and a more efficient allocation of capital. We believe we have significant opportunities for continued improvement in the second half of 2008. Above all, we remain focused on delivering value to

> both our shareholders and the communities we serve.

(Emphasis added).

268. The foregoing representations in ¶¶266-267, *supra*, were materially false and misleading because CHS failed to disclose that CHS's "business model" and its efforts to "integrate" its newly acquired hospitals were driven, in large part, by CHS's implementation of improper and unsustainable operating strategies, including the Blue Book's aggressive, non-industry standard admissions criteria, programming Pro-MED to generate tests and procedures in the ER that were not clinically necessary in order to raise patient acuity levels, and a quota incentive system, which had the cumulative effect of drastically increasing the number of one-day stays while decreasing the observation rate.

269. On August 5, 2008, the Company filed its quarterly report for the second quarter with the SEC on a Form 10-Q, which was signed by CEO Smith and CFO Cash (the "Q2 2008 Form 10-Q"). The Q2 2008 Form 10-Q reiterated the previously announced financial results.

270. On July 29, 2008 CHS held its Q2 2008 earning conference call. On the call, Smith and Cash discussed CHS's ER admissions:

> W. Larry Cash: Yeah, Darren, *one thing's happened as we had pretty good growth with ER admissions which generally are a little bit less acuity business. So while we've got very good admissions growth, it is a little bit less acuity.* Our patient days are down slightly, and I think

> our [inaudible] day was down about 5%, being two-tenths of a day....
>
> Wayne Smith: One other thing, Darren, and just to follow up on Larry's comment about - One of the things that we thought we had a good opportunity with the Triad [inaudible] as well as improving ER admissions in our - emergency admissions are up over 3% or so. When you do that, you're clearly going to have less acuity, and that's adversely affecting our case mix to some extent.
>
> Wayne Smith: *One of the things that's maybe driving some of our volume is that we've had an – we've been working hard on these emergency rooms, and increased our emergency room admissions of over 3%, and we are getting a little less acuity in terms of those, and that would be expected when you start really pushing them and working to improve your emergency services.*

(Emphasis added).

271. The foregoing representations in ¶¶269-270, were materially false and misleading because CHS failed to disclose how it was able to achieve admissions growth through the ED, despite the fact that less acuity patients access the ED. Specifically, CHS failed to disclose that its inpatient admissions results through the ED were driven in large part by its implementation of its unsustainable operating strategy designed to drive patients into inpatient admissions despite the lack of a clinical basis to do so.

272. On the same earnings call Cash commented on CHS's year-to-date admission growth:

> Well, if you – We went into the year at 0.5 to 1.5. We had a really strong flu season, and of course that's what's [inaudible] and we've also got leap year in the first quarter. You look at the second half the year, you wouldn't want to anticipate a flu coming in the fourth quarter. . . . So we sort of went back to looking at more of where we thought was still good growth, maybe around 1% or 1.5% growth for the rest of the year, which is less than we've been for the first two quarters. Hopefully the programs we got in place will have us do better than that. We clearly are working to do better than that and we hope our hospitals do better, but that was the guidance.

273. The foregoing representation in ¶272, *supra*, was materially false and misleading because CHS failed to disclose that its admission growth was driven, in large part, to the Company's implementation of undisclosed strategies, including the Blue Book's aggressive, non-industry standard admissions criteria, programming Pro-MED to generate tests and procedures in the ER that were not clinically necessary in order to raise patient acuity levels, and a quota incentive system, which had the cumulative effect of drastically increasing the number of one-day stays while decreasing the observation rate.

Third Quarter 2008

274. On October 29, 2008, CHS issued a release announcing its financial and operating results for the third quarter ended on September 30, 2008 (the "Q3 2008 Earnings Release"). The company reported net operating revenues of $2.773 billion, a 23.4 percent increase compared to $2.247 billion for the same

period of the prior year. The Company further reported a net income of $50.4 million, or $0.53 diluted earnings per share for the quarter, compared to $10.5 million, or $0.11 diluted earnings per share for the same period of the prior year. CHS also reported a 22.6% increase in total admissions compared to the same period of the prior year. On a same-store basis, admissions increased 2.3%, compared to the same period of the prior year. CHS also discussed its recent acquisition of Empire Health Services located in Spokane, Washington.

275. In commenting on the results, CEO Smith stated:

> *We continued to benefit from an improving performance at the hospital level, as evidenced by solid same-store volume gains and favorable revenue trends. These results confirm that the fundamentals of our business are strong and our centralized operating strategy is working across all of our markets.* Despite a challenging macro-environment, we look forward to continued progress for the remainder of 2008 and beyond as a result of our consistent execution.
>
> * * * *
>
> We were very pleased to complete the Empire acquisition on favorable terms after a lengthy negotiation and approval process. *We look forward to another opportunity to expand our market reach and implement our strategy for improving operations in this health system. We believe our strong track record with respect to acquisitions demonstrates that we are well positioned to again deliver favorable results.*

(Emphasis added).

276. On October 31, 2008, the Company filed its quarterly report for the third quarter with the SEC on a Form 10-Q, which was signed by Smith and Cash (the "Q3 2008 Form 10-Q"). The Q3 2008 Form 10-Q reiterated the previously acknowledged financial results.

277. On October 30, 2008, CHS held its Q3 2008 earnings conference call. On the call, CEO Smith touted CHS's ability to improve margins at newly-acquired hospitals:

> But the thing that differentiates us, I think, from a lot of our competitors is that we again, think we have a lot of upside potential here, and that *we bought a number of hospitals that had relatively low margins, both prior to the time we did the Triad, and a number of the Triad hospitals had relatively low margins.* And one thing that has happened to us over the last 12 months is that we have an outstanding group of executives that has not only stepped up and worked their way through this combination of these two gotten – *taken advantage of all the synergies, but from an operating standpoint*, across-the-board in our 118 facilities, our executives are performing extremely well and that's made a big difference.

(Emphasis added).

278. The foregoing representations in ¶¶274-277, *supra*, were materially false and misleading because CHS failed to disclose that its financial growth was driven, in large part, by the Company's implementation of undisclosed strategies, including

the Blue Book's aggressive, non-industry standard admissions criteria, programming Pro-MED to generate tests and procedures in the ER that were not clinically necessary in order to raise patient acuity levels, and a quota incentive system, which had the cumulative effect of drastically increasing the number of one-day stays while decreasing the observation rate. In addition, these statements were materially false and misleading because Defendants failed to disclose that its results after acquiring Triad were driven by CHS's implementation of these same improper strategies.

Fourth Quarter and Full Year 2008

279. On February 19, 2009, CHS issued a release announcing its financial and operating results for the fourth quarter and year ended December 31, 2008 (the "Q4 2009 Earnings Release"). The Company reported net operating revenues of $2.762 billion, a 10.9 percent increase compared to $2.490 billion for the same period of the prior year. The Company further reported a net income of $59.9 million, or $0.65 diluted earnings per share for the quarter, compared to a loss of $88.3 million or $0.94 diluted earnings per share for the same period of the prior year.

280. Touting the year end results, Smith stated:

> The fourth quarter of 2008 capped off another outstanding year for Community Health Systems, Inc., highlighted by record annual revenues of over $10.8 billion....
>
> *Most importantly, we have shown our ability to deliver favorable operating results through our efforts to implement best practices in all of our*

> *facilities across the country. We have a very conservative operating strategy and are mindful of the critical need to manage our costs and drive margin, particularly in this economic environment. We see considerable opportunities to realize additional operating synergies at our more recently acquired hospitals, including the facilities acquired in the Triad merger.*

(Emphasis added).

281. On February 27, 2009, the Company filed its 2008 annual report on Form 10-K, which was signed by CEO Smith and CFO Cash (the "2008 Form 10-K"). The Company made substantially similar statements to those stated above in ¶¶228, 230-233 in its 2008 Form 10-K filed on February 27, 2009 at pp. 2-3, 5-6, 12-13, 19.

282. On February 20, 2009, CEO Smith and CFO Cash presided over CHS's fourth quarter earnings conference call. On the call, CEO Smith commented on CHS's same-store admissions for 2008:

> Let me kind of start in terms of our view of where we are in terms of same-store. We had a very strong year. Our same-store volumes were up 2%. I think it's clearly higher than anybody else in the industry even though we had a weak fourth quarter for a number of reasons. And we think the first quarter is a difficult quarter because of the fact of we had flu last year and we had a leap year.
>
> But having said that, we're pretty confident about our 1 to 2% increase in same-store volume going forward for the year and primarily around the fact that it's sort of the basics that we

> continue to talk about. We only have about 50% market share. So we have a lot of our opportunity in terms of growing our markets going forward. Our case mix index is still relatively low so we have opportunity for not only volume growth but we have opportunity in terms of intensity growth.

283. On the same earnings call, CFO Cash discussed CHS's Medicare case mix on a same-store basis:

> That's the entire base of – including the Triad hospitals as best we can put together from January when we attempted to have same-store – have Triad in it from January 1 of 2007. One reason the 90 basis points was the strong flu season in our first quarter of 2009 brought case mix down. *And then we've had a fair amount of success in ER management, which will sometimes bring in a little bit lower acuity admissions.*

(Emphasis added).

284. The foregoing representations in ¶¶279-283, *supra*, were materially false and misleading because CHS failed to disclose that its financial growth, "success in ER management," were driven in large part, by the Company's implementation of undisclosed strategies, including the Blue Book's aggressive, non-industry standard admissions criteria, programming Pro-MED to generate tests and procedures in the ER that were not clinically necessary in order to raise patient acuity levels, and a quota incentive system, which had the cumulative effect of drastically increasing the number of one-day

stays while decreasing the observation rate. In addition, the representation in ¶280, *supra*, that CHS implemented "best practices at all [its] facilities" and utilized a "very conservative operating strategy" were materially false and misleading in light of these practices. The representation in ¶283, *supra*, was also materially false and misleading, because CHS failed to disclose how it was able to have "success in ER management," despite the ER bringing in lower acuity admissions.

First Quarter 2009

285. On April 23, 2009, CHS issued a release announcing its financial and operating results for the first quarter ended March 31, 2009 (the "Q12009 Earnings Release"). The Company reported net operating revenues of $2.892 billion, a 7.6 percent increase compared to $2.689 billion for the same period of the prior year. The Company further reported a net income of $58.9 million, or $0.65 diluted earnings per share for the quarter, compared to $60.1 million, or $0.63 diluted earnings per share for the same period for the year prior.

286. In the Ql 2009 Earnings Release, Smith described CHS's first quarter performance this way:

> We are pleased with our solid financial performance for the first quarter of 2009. *These results reflect our proven operating strategy and our ability to drive revenues and improve the financial performance of our hospitals in spite of a challenging operating environment. We will continue to manage our operations as efficiently* as possible in this uncertain economy and, at the

> same time, meet our commitment to provide quality healthcare in the communities we serve.

(Emphasis added).

287. The foregoing representations in ¶¶1285-286, *supra*, were materially false and misleading because CHS failed to disclose that its financial growth was driven in large part, by the Company's implementation of undisclosed strategies, including the Blue Book's aggressive, non-industry standard admissions criteria, programming Pro-MED to generate tests and procedures in the ER that were not clinically necessary in order to raise patient acuity levels, and a quota incentive system, which had the cumulative effect of drastically increasing the number of one-day stays while decreasing the observation rate.

288. On April 29, 2009, the Company filed its quarterly report for the first quarter with the SEC on a Form 10-Q, which was signed by Smith and Cash (the "Q1 2009 Form 10-Q"). In the Q1 2009 Form 10-Q, the Company stated:

> Despite these uncertainties in the economy, our net operating revenue for the three months ended March 31, 2009 increased to $2.892 billion, as compared to $2.689 billion for the three months ended March 31, 2008. Income from continuing operations, before noncontrolling interests, for the three months ended March 31, 2009 increased 20.3% over the three months ended March 31, 2008. This increase during the three months ended March 31, 2009, as compared to the three months ended March 31, 2008 is due primarily to an

> increase in billing rates, an increase in surgeries performed at our hospitals, *the realization of synergies from the Triad acquisition and the recognition of cost savings from our ability to effectively control costs.*

(Emphasis added).

289. The foregoing representations in ¶288, *supra*, were materially false and misleading because CHS failed to disclose that its financial growth and its results after acquiring Triad were driven by CHS implementing its improper and unsustainable admissions practices at former Triad hospitals, as detailed above, to steer patients into inpatient treatment despite the lack of a clinical basis for these patients to be admitted into the hospital, and that any "synergies" CHS realized from the Triad acquisition were the result of CHS's implementation of these improper and unsustainable admissions practices.

Second Quarter 2009

290. On July 30, 2009 CHS issued a release announcing its financial and operating results for the second quarter ended June 30, 2009 (the "Q2 2009 Earnings Release"). The Company reported net operating revenues of $3.017 billion, a 12.9 percent increase compared to $2.673 billion for the same period of the prior year. The Company further reported a net income of $59.4 million, or $0.65 diluted earnings per share for the quarter, compared to $47.9 million, or $0.50 diluted earnings per share for the same period of the prior year.

291. Smith commented on the Q2 2009 results, as follows:

> Community Health Systems continued to deliver a solid operating performance for the second quarter of 2009, in spite of the challenging economic environment. *Our ability to drive revenues and demonstrate efficient expense management reflects consistent execution of our strategy. While the expected economic trends indicate that overall hospital industry volumes will remain under pressure for the remainder of 2009, we believe our proven operating model will favorably support our business through this uncertain environment.* Our geographically diverse hospital portfolio also provides us with a competitive advantage with less exposure to more economically depressed markets.
>
> *We see considerable opportunities to realize additional operating synergies at our more recently acquired hospitals.* We have demonstrated our ability to deliver improved operating results *through our efforts to implement best practices* in all of our facilities across the country. We have a very conservative operating strategy and are mindful of the critical need to manage our costs. *With our proven track record, we are highly focused on continued improvement from our facilities with the most opportunity for growth.*

(Emphasis added).

292. These statements were materially false and misleading because CHS failed to disclose that any expected operating synergies from its newly acquired hospitals were and would be driven in large part, by the Company's implementation of undisclosed strategies, including the Blue Book's aggressive,

non-industry standard admissions criteria, programming Pro-MED to generate tests and procedures in the ER that were not clinically necessary in order to raise patient acuity levels, and a quota incentive system, which had the cumulative effect of drastically increasing the number of one-day stays while decreasing the observation rate. In addition, these statements were materially false and misleading because in light of the fact that CHS failed to disclose its "proven operating model" included improper and unsustainable admissions practices, as discussed in detail above.

293. On July 31, 2009, the Company filed its quarterly report for the second quarter with the SEC on a Form 10-Q, which was signed by Smith and Cash (the "Q2 2009 Form 10-Q"). In the Q2 2009 Form 10-Q, CHS highlighted:

> Despite these uncertainties in the economy, our net operating revenue for the three months ended June 30, 2009 increased to $3.017 billion, as compared to $2.673 billion for the three months ended June 30, 2008. Income from continuing operations, before noncontrolling interests, for the three months ended June 30, 2009 increased 34.5% over the three months ended June 30, 2008. This increase in income from continuing operations during the three months ended June 30, 2009, as compared to the three months ended June 30, 2008, is due primarily to an increase in surgeries performed at our hospitals, strong outpatient growth, *the realization of synergies from our acquisition of Triad Hospitals, Inc., or Triad,* and the recognition of cost savings from our ability to

> effectively control costs. Total admissions for the three months ended June 30, 2009 increased 5.8% compared to the three months ended June 30, 2008. This increase in admissions was due primarily to our recent acquisitions.

(Emphasis added).

294. The foregoing representations in ¶293, *supra*, were materially false and misleading because CHS failed to disclose that any expected operating synergies, its financial growth and its results after acquiring Triad were in large part driven by CHS implementing its improper and unsustainable admissions practices at former Triad hospitals, as detailed above, to steer patients into inpatient treatment despite the absence of a clinical basis for these patients to be admitted into the hospital, and that any synergies CHS realized from the Triad acquisition were the result of CHS's implementation of this improper and unsustainable admissions practices.

Third Quarter 2009

295. On October 28, 2009, CHS issued a release announcing its financial and operating results for the third quarter and nine months ending September 30, 2009 (the "Q3 2009 Earning Release"). The Company reported net operating revenues of $3.087 billion, a 12.1 percent increase compared to $2.755 billion for the same period of the prior year. The Company further reported a net income of $59.7 million, or $0.65 diluted earnings per share compared to $50.4 million or $0.53 diluted earnings per share for the same period of the prior year.

296. CEO Smith commented:

> We are pleased with our solid financial and operating performance in the third quarter of 2009, *as we again exceeded expectations*. We continued to benefit from a consistent performance at the hospital level, as evidenced by favorable revenue trends and same-store margin expansion. *These results confirm that the fundamentals of our business are strong and our centralized operating strategy is working across all of our markets.*
>
> We believe our proven ability to enhance essential healthcare services and recruit and retain qualified physicians in our markets will help support our continued growth. Our conservative operating strategy has served us well, and we are mindful of the critical need to manage our costs and drive margins. *We see considerable opportunities to leverage our assets and realize additional operating improvements at our more recently acquired hospitals. We are pleased with the trends in our business and we look forward to continued progress for the remainder of 2009 and into 2010.*

(Emphasis added).

297. On October 30, 2009, the Company filed its quarterly report for the third quarter with the SEC on a Form 10-Q, which was signed by Smith and Cash (the "Q3 2009 Form 10-Q"). In the Q3 2009 Form 10-Q, CHS reiterated its opportunity for growth:

> We believe there continues to be ample opportunity for growth in substantially all of our markets by decreasing the need for patients to

> travel outside their communities for health care services. Furthermore, *we continue to benefit from synergies from the acquisition of Triad as well as our more recent acquisitions and will continue to strive to improve operating efficiencies and procedures in order to improve our profitability at all of our hospitals.*

(Emphasis added).

298. The foregoing representations in ¶295-297, *supra*, regarding synergies and improved operating efficiencies and procedures at its newly acquired hospitals were materially false and misleading because CHS failed to disclose that improved results were driven in large part by CHS's implementation of its admissions practices at these newly acquired hospitals to steer patients into inpatient treatment despite the absence of a clinical basis for these patients to be admitted into the hospital. Further, these statements attributing favorable trends in revenues and margins to strong business fundamentals and a "centralized operating strategy" were materially false and misleading because CHS failed to disclose that its favorable results were also driven in large part by CHS implementing its improper and unsustainable admissions practices and overbilling Medicare.

Fourth Quarter and Full Year 2009

299. On February 17, 2010, CHS issued a release announcing its financial and operating results for the fourth quarter ended December 31, 2009 (the "Q4 2009 Earnings Release"). The Company reported net operating revenues of $3.1 billion, a 11.1 percent increase compared to $2.8 billion for the same period

of the prior year. The Company further reported a net income of $65.1 million, or $0.70 diluted earnings per share for the quarter, compared to $59.9 million, or $0.65 diluted earnings per share for the same period of the prior year.

300. Commenting on the year end results, CEO Smith stated:

> We are very pleased to report another successful year for Community Health Systems. Our financial and operating performance for the fourth quarter 2009 reflects our proven ability to deliver consistent quarterly results, even in the face of a challenging economy. We ended the year with record consolidated revenues of over $12.1 billion, up eleven percent over the previous year. *Our results also reflect the continued success of our centralized operating strategy as evidenced by favorable annual same-store revenue growth and solid margin expansion. We have continued to focus on improving the performance at the individual hospital level in all of our markets, especially at our more recently acquired facilities.*
>
> As we look ahead to 2010, we see additional opportunities for continued growth for Community Health Systems. As a national hospital operator, our geographically diverse portfolio has always been one of our strengths, especially in an uncertain economic environment. Our hospitals have strong positions in each of their respective markets and no one state represents a disproportionate percentage of our revenues or admissions. We remain focused on the fundamentals of our

> business and believe our proven success in enhancing essential healthcare services, driving efficiencies, and recruiting and retaining qualified physicians in our markets will continue to support our long term growth strategies.

(Emphasis added).

301. The foregoing representations in ¶¶299-300, *supra*, were materially false and misleading because CHS failed to disclose that its "centralized operating strategy," which accounted for its financial growth and record consolidated revenues were driven, in large part, by the Company's implementation of undisclosed strategies, including the Blue Book's aggressive, non-industry standard admissions criteria, programming Pro-MED to generate tests and procedures in the ER that were not clinically necessary in order to raise patient acuity levels, and a quota incentive system, which had the cumulative effect of drastically increasing the number of one-day stays while decreasing the observation rate. Further, CHS failed to disclose that in order to improve the performance, especially at CHS's "more recently acquired facilities," CHS would implement its admissions practices, discussed in detail above, designed to drive patients into inpatient treatment despite the lack of a clinical basis for these patient to be admitted into the hospital.

302. On February 26, 2010, the Company filed its 2009 annual report on Form 10-K, which was signed by CEO Smith and CFO Cash (the "2009 Form 10-K"). In addition, the Company made substantially similar statements to those stated

above in ¶¶228, 230-233 in its 2009 Form 10-K filed on February 26, 2010 at pp. 1-6, 12-13, 19-20.

303. The 2009 Form 10-K also described CHS's admissions and operating results as follows:

> Net operating revenues increased by 10.9% to approximately $12.1 billion in 2009, from approximately $10.9 billion in 2008. Growth from hospitals owned throughout both periods contributed $639 million of that increase and $550 million was contributed by hospitals acquired in 2009 and 2008. On a same-store basis, net operating revenues increased 5.9%. The increase from hospitals that we owned throughout both periods was primarily attributable to higher acuity level of services provided and outpatient growth, along with rate increases and favorable payor mix. These improvements were partially offset by the stronger flu and respiratory season during the year ended December 31, 2008, as compared to the year ended December 31, 2009, and the extra day from the leap year in 2008.
>
> ... On a same-store basis, inpatient admissions decreased by 1.5% during the year ended December 31, 2009. This decrease in inpatient admissions was due primarily to the strong flu and respiratory season during the year ended December 31, 2008, which did not recur during 2009, the 2008 period having one additional day because it was a leap year, and the impact of closing certain less profitable services.

304. On February 18, 2010, CHS held its Q4 2009 earnings conference call. Cash attributed a

decline in revenue to lower inpatient volume in the managed care segment.

305. The foregoing representations in ¶¶302-304, *supra*, were materially false and misleading because CHS failed to disclose that, despite experiencing a decrease in overall same-store inpatient admissions, CHS was continuing implement its undisclosed strategies, including the Blue Book's aggressive, non-industry standard admissions criteria, programming Pro-MED to generate tests and procedures in the ER that were not clinically necessary in order to raise patient acuity levels, and a quota incentive system, which had the cumulative effect of drastically increasing the number of one-day stays while decreasing the observation rate. As a result, admissions through the ED continued to rise. For example, in a CHS Board Presentation titled REDACTED

306. These foregoing representations were also materially false and misleading because CHS failed to disclose that it was far more vulnerable than its peers to pressure from managed care companies to shift admitted patients to observation status in light of CHS's improper and unsustainable admissions practices, which resulted in CHS vastly underutilizing observation status as compared to CHS's peer hospital operators.

First Quarter 2010

307. On A,pril 21, 2010, CHS issued a release announcing its financial and operating results for the first quarter ended March 31, 2010 (the "Ql 2010 Earnings Release"). The Company reported net operating revenues of $3.2 billion, a 8.5 percent

increase compared to $2.9 billion for the same period of the prior year. The Company further reported a net income of $70.0 million, or $0.75 diluted earnings per share for the quarter, compared to $58.9 million, or $0.65 diluted earnings per share for the same period of the prior year.

308. In the Ql 2010 Earnings Release, Smith acknowledged:

> We are pleased with our solid financial and operating performance for the first quarter of 2010. We have continued to focus on driving operating synergies at the individual hospital level, especially at our more recently acquired facilities. *Our success as an operator is supported by consistent growth in revenues and earnings, in spite of a challenging economic environment. These results confirm that the fundamentals of our business are strong and our centralized operating strategy is working across our markets.*
>
> Looking ahead, our primary focus for 2010 will be on leveraging our existing assets and improving our operations by focusing on the key areas for success in our business – *a proven operating model*, disciplined expense management, a successful physician recruitment program, and strategic capital investments. While we acknowledge the changing dynamics in today's healthcare marketplace, we remain confident in our ability to execute our strategy and deliver favorable results.

(Emphasis added).

309. On April 28, 2010, the Company filed its quarterly report for the first quarter with the SEC on a Form 10-Q, which was signed by Smith and Cash (the "Ql 2010 Form 10-Q"). In discussing the quarter's results, the Q1 2010 10-Q stated:

> Our net operating revenue for the three months ended March 31, 2010 increased to approximately $3.2 billion, as compared to approximately $2.9 billion for the three months ended March 31, 2009. Income from continuing operations, before noncontrolling interests, for the three months ended March 31, 2010 increased 20.0% over the three months ended March 31, 2009. This increase in income from continuing operations during the three months ended March 31, 2010, as compared to the three months ended March 31, 2009, *is due primarily to the growth in revenues from recently acquired hospitals as well as those owned throughout both periods coupled with our effective management of operating expenses.* Our successful physician recruiting efforts have also been a key driver in the execution of our operating strategies. Total inpatient admissions for the three months ended March 31, 2010 increased 3.0%, compared to the three months ended March 31, 2009, and adjusted admissions for the three months ended March 31, 2010 increased 4.7%, compared to the three months ended March 31, 2009. This increase in inpatient and adjusted admissions was due primarily to acquisitions during the past twelve months.

(Emphasis added).

310. On April 22, 2010, CHS held the Ql 2010 earnings conference call. On the call, Cash reported that same-store admissions decreased 1.2%, due in part to "reductions in one-day stays with a corresponding increase in outpatient observations."

311. The foregoing representations in ¶¶307-310, *supra*, were materially false and misleading because CHS failed to disclose that it was continuing, in large part, to implement undisclosed strategies, including the Blue Book's aggressive, non-industry standard admissions criteria, programming Pro-MED to generate tests and procedures in the ER that were not clinically necessary in order to raise patient acuity levels, and a quota incentive system, which had the cumulative effect of drastically increasing the number of one-day stays while decreasing the observation rate. As a result, despite experiencing a decrease in overall same-store admissions due to pressure from managed care providers to reduce one-day stays, admissions through the ED continued to rise, as set forth in ¶305.

Second Quarter 2010

312. On July 28, 2010, CHS issued a release announcing its financial and operating results for the second quarter ended June 30, 2010 (the "Q2 2010 Earnings Release"). The Company reported net operating revenues of $3.2 billion, a 5.1 percent increase compared to $3.0 billion for the same period of the prior year. The Company further reported a net income of $70.1 million, or $0.74 diluted earnings per share for the quarter, compared to $59.4 million, or $0.65 diluted earnings per share for the same period of the prior year.

313. In discussing Q2 2010 results, Smith stated:

> Community Health Systems delivered another solid operating performance for the second quarter of 2010, in spite of the ongoing challenges in the economy. *Our ability to continue to drive revenues and achieve solid margins demonstrates consistent execution of our centralized operating strategy and our focus on efficient expense management throughout our hospital network.*
>
> We have continued to selectively acquire new facilities that fit our operating profile. In today's economic environment, there are a growing number of hospitals who want a proven operator to provide the resources and expertise that will enable them to deliver quality healthcare close to home. *We have consistently demonstrated our ability to deliver favorable operating results through our efforts to implement best practices in all of our hospitals.*

(Emphasis added).

314. On July 30, 2010, the Company filed its quarterly report for the second quarter with the SEC on a Form 10-Q, which was signed by Smith and Cash (the "Q2 2010 Form 10-Q"). The Q2 2010 Form 10-Q results reiterated the CHS's reported financial results.

315. On July 29, 2010, CHS held the Q2 2010 earnings conference call. Cash reported that "same-store admissions decreased 2.5%" due in part to "a reduction in one-day admissions with a corresponding increase in outpatient observation of 70 basis points."

316. The foregoing representations in ¶¶312-315, *supra*, were materially false and misleading because CHS failed to disclose that its success as an acquirer, its operational performance and its "ability to deliver favorable operating results through [its] efforts to implement best practices" and the "consistent execution of our centralized operating strategy" were in large part due to the systematic implementation of improper and unsustainable admissions practices. Specifically, the Company continued to implement its undisclosed strategies, including the Blue Book's aggressive, non-industry standard admissions criteria, programming Pro-MED to generate ER tests and procedures in the ER that were not clinically necessary in order to raise patient acuity levels, and a quota incentive system, which had the cumulative effect of drastically increasing the number of one-day stays while decreasing the observation rate. As a result, despite a decrease in overall same-store admissions, ED admissions continued to rise, as set forth in ¶305.

Third Quarter 2010

317. On October 27, 2010, CHS issued a release announcing its financial results for the third quarter ended September 20, 2010 (the "Q3 2010 Earnings Release"). The Company reported net operating revenues of $3.3 billion, a 5.4 percent increase compared to $3.1 billion for the same period of the prior year. The Company further reported a net income of $70.4 million, or $0.76 diluted earnings per share for the quarter, compared to $59.7 million, or $0.65 diluted earnings per share for the same period of the prior year.

318. In commenting on the results, CEO Smith stated:

> We are pleased with our solid financial performance for the third quarter of 2010, in what has continued to be a challenging economic environment. Our conservative operating strategy and strong focus on expense management have served us well. *We continued to benefit from a consistent performance at the hospital level, as evidenced by favorable same-store revenue trends for the third quarter and year to date periods.*
>
> Throughout 2010, we have continued to extend our market reach through selective acquisitions. We have identified hospital facilities that meet our operating profile with the most opportunity for growth. *We have a proven track record for the successful integration of these facilities with improved operating results.* With the current healthcare regulatory climate, we believe there are significant opportunities for us to pursue additional acquisitions with a greater number of independent hospitals looking for established and operationally-focused partners. We can provide the experience and financial resources to support and keep these hospitals in the local community. We look forward to working together with each new hospital partner as we deliver on our commitment to deliver quality healthcare close to home.

(Emphasis added).

319. On October 29, 2010, the Company filed its quarterly report for the second quarter with the SEC

on a Form 10-Q, which was signed by CEO Smith and CFO Cash (the "Q3 2010 Form 10-Q"). The Q3 2010 Form 10-Q reiterated the previously announced financial results.

320. On October 28, 2010, CHS held the Q3 2010 earnings conference call. As in the prior two quarters of 2010, Cash reported that same-store admissions decreased 3.6% in part to a "reduction[ ] in one-day stays with the corresponding increase in outpatient observations."

321. The foregoing representations in ¶¶317-320, *supra*, were materially false and misleading because CHS failed to disclose that its "proven track record for the successful integration of 'its newly acquired facilities, was driven by CHS's implementation and execution of its admissions practices at these newly acquired hospitals, designed to steer patients into inpatient treatment despite the absence of a clinical basis for these patients to be admitted into the hospital. In addition, CHS also failed to disclose that, despite experiencing a decrease in overall same-store admission, it was continuing, to implement the Company's undisclosed strategies, including the Blue Book's aggressive, non-industry standard admissions criteria, programming Pro-MED to generate ER tests and procedures in the ER that were not clinically necessary in order to raise patient acuity levels, and a quota incentive system, which had the cumulative effect of drastically increasing the number of one-day stays while decreasing the observation rate. As a result, admissions through the ED continued to rise.

Fourth Quarter and Full Year 2010 CHS's Attempt to Takeover Tenet

322. On December 9, 2010, CHS issued a press release announcing a cash-and-stock proposal to acquire Tenet at $6.00 per share. In the press release, which was filed with the SEC, CHS stated, *inter alia*, that CHS had a "reputation for superior operating performance and a successful track record of integrating acquisitions." CHS also stated that its "ability to enhance the operating efficiencies and best practices of a combined organization would enable it to provide even higher quality for patients...."

323. CHS attached as an exhibit to its press release a copy of a presentation entitled "Community Health Systems and Tenet Healthcare: A Compelling Opportunity For Value Creations."[10] The presentation, among other things, discussed the "significant synergy potential" between CHS and Tenet. CHS also stated that the "Transaction Benefits Key Constituents," including patients, who would experience "[i]mproved quality of care from standardized best practices and clinical protocols."

324. These statements concerning superior operating performance and synergies were materially false and misleading in light of CHS's failure to disclose that, for at least a decade, the number of patients admitted into CHS hospitals was the product of CHS's improper practices, discussed in

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[10] In this filing, CHS acknowledged that "The Company and its directors and executive officers and other persons may be deemed to be participants in any solicitation of proxies from Tenet's stockholders in respect of the proposed transaction with Tenet..."

detail above, to drive patient admissions despite the absence of a clinical basis for these patients to be admitted into the hospital. Specifically, CHS failed to disclose that CHS had engaged in an effort to increase its patient admissions through implementation of the improper admission practices that, under industry standard clinical criteria, should have been treated in observation. These undisclosed practices exposed Medicare and other payers to millions of dollars of improper additional costs. CHS's purported reputation as a successful operator and acquirer was based on this same improper conduct.

325. On December 10, 2010, CHS hosted an analyst call to discuss CHS's proposed acquisition of Tenet. On the call, Defendant Smith touted CHS's "proven track record of unmatched operating performance," including through CHS's acquisition of Triad, which CHS "successfully integrated." In particular, Smith claimed that CHS was able to, effectively integrate Triad because "we have a very standardized, centralized platform, operating platform."

326. The foregoing representations were materially false and misleading in light of the same material omissions concerning CHS's admissions practices set forth above. In particular, Defendants failed to disclose the improper admission practices, the decreased rate of observation, and the increase in one-day stays at the Triad hospitals in the year following the acquisition. In addition, these statements were materially false and misleading because Defendants failed to disclose that CHS faced substantial potential liability due to its undisclosed

admissions practices and regulatory investigations relating thereto.

327. On December 20, 2010, CHS issued a press release, which it filed with the SEC, announcing that it was commencing a proxy contest to take control of Tenet Board of Directors, at Tenet's upcoming 2011 annual meeting.

328. On January 11, 2011 at the J.P. Morgan Healthcare Conference, Smith discussed, inter alia, CHS's offer to buy Tenet as well as CHS's business strategy:

> So when you think about us, we think we have a very clear executable strategy. It's predictable. It's sustainable, as we've proven over the last 10 years.....
>
> And definitely *we've a proven operating permanent strategy that works with consistent financial performance and margin improvement*.

(Emphasis added).

329. During the January 11th Conference, Smith stated that CHS is an "Industry Leader in Admissions Growth," and provided data purported to reflect that CHS's admissions and adjusted patient admissions had grown in every year from 2000 to 2009. In addition, CHS stated that one of its "Significant Opportunities for Growth in Revenue and Operating Profit" is to "Increase Inpatient ER Visits." CHS further stated that it§ "ER Strategy" has "[c]ontributed to same store admission growth." Moreover, with regard to its operating strategy, CHS made statements about its purported success at "Improv[ing] Hospital Operations" through "Standardization and Centralization," including

CHS's "Billing and Collections" and "Quality/Resource/Case Management" functions. Smith also stated that CHS had a "very sound operating strategy," a "very clear executable strategy, [that] is predictable, [and] is sustainable, as we've proven over the last ten years," and a "proven operating ... strategy that works with a consistent financial performance and margin improvement."

330. The statements in ¶¶328-329 were materially false and misleading in light of CHS's failure to disclose that its admissions numbers, ER strategy, and operating strategy depended on CHS's improper admissions practices, discussed in detail above. Specifically, CHS failed to disclose that CHS had engaged in a systemic practice of increasing its patient admissions through implementation of the Blue Book criteria that resulted in the admission of patients into CHS hospitals who, under industry standard clinical criteria, should have been treated in observation. Defendants also failed to disclose that its "ER strategy" included programming Pro-MED to generate tests and procedures that were not clinically necessary in order to raise patient acuity levels as detailed above to justify unwarranted inpatient admissions. CHS also failed to disclose the substantially potential financial liability it faces from these admissions practices and from the ongoing regulatory investigations related thereto.

331. During his January 11, 2011 presentation at the JP Morgan Investor Conference, Smith also made affirmative representations about CHS's success as an acquirer of hospitals, and in particular, CHS's purported success in acquiring and integrating hospitals acquired from Triad in 2007.

In particular, Smith boasted that: "we've improved the margin about 280 basis points and we got about $275 million of synergies out of those facilities."

332. Moreover, CHS provided data that purported to show, on a revenue and EBITDA basis, that hospitals acquired by CHS performed better after being acquired by CHS. CHS further stated that "CHS Management Significantly Improved Triad's Operating Results," and that CHS had "[s]uccessfully integrated [the] Triad acquisition."

333. The statements in ¶¶331-332 were materially false and misleading in light of CHS's failure to disclose that the positive results after acquiring Triad were driven by CHS implementing its admissions practices at former Triad hospitals, discussed in detail above, to steer patients into inpatient treatment despite the absence of a clinical basis for these patients to be admitted into the hospital.

334. On February 8, 2011, Defendant Smith delivered a presentation at the UBS Global Healthcare Services Conference; excerpts of Smith's remarks at the UBS conference were filed with the SEC. These material contained similar material misstatements as Smith made in prior healthcare conferences. For example, Smith touted CHS's ability to improve margins and performance in its acquired hospitals, citing the Triad acquisition as the primary example. Smith also referred to the supposed "synergies" CHS achieved in the Triad acquisition and asserted that, with respect to Tenet, there "is a lot of opportunity in terms of the synergies."

335. These statements were materially false and misleading in light of CHS's failure to disclose that its results after acquiring Triad were driven by CHS implementing its improper admissions practices at former Triad hospitals, discussed above, designed to drive up inpatient admissions despite the lack of clinical basis for these patients to be admitted into the hospital rather than observed.

336. On February 24, 2011 CHS issued a release announcing its financial and operating results for the three months and year ending December 31, 2010 (the "Q4 2010 Earnings Release"). The Company reported net operating revenues of $3.4 billion, a 10.1 percent increase compared to $3.1 billion for the same period of the prior year. The Company further reported a net income of $69.5 million, or $0.76 diluted earnings per share for the quarter, compared to $65.1 million, or $0.70 diluted earnings per share for the same period of the prior year. CHS also reported a 2.0% increase in total admissions and a 5.1% increase in total adjusted admissions, compared to the same period of the prior year.

337. Commenting on the 2010 results, CEO Smith stated:

> The fourth quarter marked a very strong finish to 2010, as we reported the highest quarterly net operating revenues of the year. *Our consistent pattern of growth reflects our success as an operator*, especially in what has continued to be a challenging economic environment. For the year, net operating revenues increased by 7.3 percent for a record $13.0 billion, and net income was up by over 15 percent to $280.0 million, or $3.01 per diluted share, another

> record for Community Health Systems. *This demonstrates that our centralized operating strategy has achieved favorable results across our markets as we have continued to focus on driving operating synergies at the individual hospital level, especially at our more recently acquired facilities.*
>
> We continued to expand our portfolio of hospitals in 2010 with a very selective acquisition strategy. We believe there are a growing number of independent hospitals that fit our criteria and can benefit from having a proven operator manage their facilities. With the ongoing uncertainties in the economy, and especially with respect to healthcare regulation, we believe there are even greater opportunities ahead for Community Health Systems to make suitable acquisitions. *We can provide the experience and operating expertise with a proven track record as a valued partner in each of the communities we serve. As we look ahead to 2011, we will continue to deliver on our commitment of quality healthcare close to home.*

(Emphasis added).

338. On February 25, 2011, the Company filed its 2010 annual report on Form 10-K, which was signed by CEO Smith and CFO Cash (the "2010 Form 10-K"). In addition, the Company made substantially similar statements to those stated above in ¶¶228, 230-233 in its 2010 Form 10-K at pp. 2-3, 5, 13, 23.

339. On February 25, 2011, CHS held a fourth quarter 2010 earnings call. On the call, Cash

reported that same-store admissions decreased 2.8% due in part to "reductions in one-day stays with a corresponding increase in outpatient observations."

340. On the same earnings call, Smith acknowledged a "national trend" toward observation, and explained that "[i]nsurers are trying to figure out ways to reduce costs." Smith suggested however, that the trend away from inpatient stays would have little impact on CHS's revenues given that "there are certain insurance companies that payment on observation is essentially the same as when [patients] stay."

341. On the same earnings call Smith reiterated that the trend was "an industry-wide issue, and I don't see anything that's problematic for us....It's just a change in location basically."

342. The foregoing representations in ¶¶336-341, *supra*, were materially false and misleading because contrary to Smith's statements and suggestion that there was little cost differential to the payor between billing a for a one-day stay as opposed to observation, and that the difference between an admission and observation is merely a change in "location," in fact CHS earns an average of approximately $3,500 more per patient for CHS's highest volume and lowest acuity admitted Medicare patients than CHS would earn if these patients had been treated in observation, and for many patients, the spread is far higher. This substantial differential translates over a several year period to hundreds of millions of dollars, according to Tenet experts.

343. These statements were also materially false and misleading in light of Defendants' failure to

disclose that the Company was far more vulnerable than its peers in the industry to pressure from payers to shift admitted patients to observation status because CHS vastly underutilized observation status by design as compared to CHS's peer hospital operators.

344. In addition, these statements were materially false and misleading because, despite experiencing a decrease in overall same-store admissions due to pressure from managed care providers to reduce one-day stays, CHS failed to disclose that, in large part, the Company continued to implement its undisclosed strategies, including the Blue Book's aggressive, non-industry standard admissions criteria, programming Pro-MED to generate tests and procedures that were not clinically necessary, and a quota incentive system, which had cumulative the effect of drastically increasing the number of one-day stays while decreasing the observation rate. As a result, admissions through the ED continued to rise.

345. These statements were also materially false and misleading because of Smith's failure to disclose the very material risk of financial liability for improper billing under Medicare. In particular, the penalties for improperly billing Medicare include treble damages and a penalty of up to $11,000 per false claim, plus the risk of exclusion from the Medicare program.

346. Smith also made statements during the earnings call concerning CHS's "success as an operator and consolidator in the industry" that CHS had "continued to focus on improving performance at the individual hospital level in all our markets,

especially at our most recently acquired facilities," and that CHS had "proven operational efficiencies." These statements were materially false and misleading in light of CHS's failure to disclose that its success as an acquirer, its operational performance and its "efficiencies" were dependent upon its undisclosed and unsustainable admissions practices discussed in detail above.

347. On March 1, 2011, Smith delivered a presentation at the Citi Global Healthcare Conference. A copy of the presentation and excerpts of Smith's remarks was filed with the SEC. These materials contained numerous materially false and misleading statements, similar to those contained in the JP Morgan Investor Conference on January 11, 2011. Smith also touted CHS's ability to improve margins and performance in its acquired hospitals, citing the Triad acquisition as the primary example.

348. These statements were materially false and misleading in light of Defendants' failure to disclose that its results after acquiring Triad were driven by CHS implementing its improper admissions practices at former Triad hospitals, discussed in detail above.

349. On March 2, 2011, Smith and Cash spoke at the RBC Capital Markets Healthcare Conference. CHS filed with the SEC excerpts of Smith's and Cash's remarks at the conference. Specifically, Smith and Cash touted CHS's ability to improve margins and performance in its acquired hospitals, citing the supposed "synergies" that CHS realized through the Triad acquisition as the primary example, and asserting that CHS would realize similar synergies by acquiring Tenet.

350. These statements were materially false and/or misleading in light of Defendants' failure to disclose that its results after acquiring Triad were driven by CHS implementing its improper admissions practices at former Triad hospitals, as discussed above.

CLASS ACTION ALLEGATIONS

351. Plaintiff brings this action as a class action pursuant to Federal Rule of Civil Procedure 23(a) and 23(b)(3) on behalf of the Class, which consists of all those who purchased or otherwise acquired CHS common stock during the Class Period and were damaged thereby. Excluded from the Class are Defendants herein, the officers and directors of the Company at all relevant times, members of their immediate families and their legal representatives, heirs, successors or assigns, and any entity in which Defendants have or had a controlling interest.

352. The members of the Class are so numerous that joinder of all members is impracticable. Throughout the Class Period, CHS common stock was actively traded on the NYSE. While the exact number of Class members is unknown to Plaintiff at this time and can be ascertained only through appropriate discovery, Plaintiff believes that there are hundreds or thousands of members in the proposed Class. Members of the Class may be identified from records maintained by CHS or its transfer agent and may be notified of the pendency of this action by mail, using the form of notice similar to that customarily used in securities class actions.

353. Plaintiff s claims are typical of the claims of the members of the Class as all members of the Class

are similarly affected by Defendants' wrongful conduct in violation of federal law that is complained of herein.

354. Plaintiff will fairly and adequately protect the interests of the members of the Class and has retained counsel competent and experienced in class and securities litigation. Plaintiff has no interests antagonistic to or in conflict with those of the Class.

355. Common questions of law and fact exist as to all members of the Class and predominate over any questions solely affecting individual members of the Class. Among the questions of law and fact common to the Class are:

(a) whether the federal securities laws were violated by Defendants' acts as alleged herein;

(b) whether statements made by Defendants to the investing public during the Class Period misrepresented material facts about the business, operations, and management of CHS;

(c) whether the Individual Defendants caused CHS to Issue false and misleading financial statements during the Class Period;

(d) whether Defendants acted knowingly or recklessly in issuing false and misleading financial statements;

(e) whether the prices of CHS common stock during the Class Period were artificially inflated because of the Defendants' conduct complained of herein; and

(f) whether the members of the Class have sustained damages and if so, what is the proper measure of damages.

356. A class action is superior to all other available methods for the fair and efficient adjudication of this controversy because joinder of all members is impracticable. Furthermore, as the damages suffered by individual Class members may be relatively small, the expense and burden of individual litigation make it impossible for members of the Class to individually redress the wrongs done to them. There will be no difficulty in the management of this action as a class action.

357. Plaintiff will rely, in part, upon the presumption of reliance established by the fraud-on-the-market doctrine in that:

(a) Defendants made public misrepresentations or failed to disclose material facts during the Class Period;

(b) the omissions and misrepresentations were material;

(c) CHS common stock is traded in efficient markets;

(d) the Company's shares were liquid and traded with moderate to heavy volume during the Class Period;

(e) the Company's common stock traded on the NYSE, and the Company received coverage by numerous securities analysts;

(f) the misrepresentations and omissions alleged would tend to induce a reasonable

investor to misjudge the value of the Company's common stock; and

(g) Plaintiff and members of the Class purchased and/or sold CHS common stock between the time the Defendants failed to disclose or misrepresented material facts and the time the true facts were disclosed, without knowledge of the omitted or misrepresented facts.

358. Based upon the foregoing, Plaintiff and the members of the Class are entitled to a presumption of reliance upon the integrity of the market.

LOSS CAUSATION/ECONOMIC LOSS

359. During the Class Period, as detailed herein, Defendants made false and misleading statements, and engaged in a scheme to deceive the market and a course of conduct that artificially inflated the price of CHS common stock and operated as fraud or deceit on Class Period purchasers of CHS common stock. Later, when Defendants' material misrepresentations and omissions became apparent to the market subsequent to the revelations made by Tenet, the price of CHS stock fell precipitously. As a result of their purchases of CHS common stock during the Class Period, Plaintiff and other members of the Class suffered economic loss, *i.e.*, damages, under the federal securities laws.

NO SAFE HARBOR

360. CHS's verbal "Safe Harbor" warnings that accompanied its oral forward-looking statements

("FLS") issued during the Class Period were ineffective to shield those statements from liability.

361. Defendants are also liable for any false FLS pleaded because, at the time each FLS was made, the speaker knew the FLS was false and the FLS was authorized and/or approved by an executive officer of CHS who knew that the FLS was false. None of the historic or present-tense statements made by Defendants were assumptions underlying or relating to any plan, projection, or statement of future economic performance, as they were not stated to be such assumptions underlying or relating to any projection or statement of future economic performance when made, nor were any of the projections or forecasts made by Defendants expressly related to, or stated to be dependent on, those historic or present tense statements when made.

CLAIMS FOR RELIEF

COUNT I

Against All Defendants for Violations of Section l0(b) and Rule l0b-5 Promulgated Thereunder

362. Lead Plaintiff repeats and realleges each and every allegation contained above as if fully set forth herein.

363. During the Class Period, Defendants engaged in a course of conduct, pursuant to which they knowingly or recklessly engaged in acts, transactions, practices, and courses of business that operated as a fraud and deceit upon Plaintiff and the

other members of the Class; and made various untrue statements of material facts and omitted to state material facts necessary in order to make the statements made, in light of the circumstances under which they were made, not misleading in connection with the purchase and sale of common stock. Such practices were intended to, and, throughout the Class Period, did: (a) deceive the investing public, including Lead Plaintiff and other Class members, as alleged herein; (b) artificially inflate and maintain the market price of CHS common stock; and (c) cause Lead Plaintiff and other members of the Class to purchase CHS common stock at artificially inflated prices. In furtherance of this course of conduct, Defendants, and each of them took the actions set forth herein.

364. Information showing that the Individual Defendants acted knowingly, or with reckless disregard for the truth, is peculiarly within knowledge and control, because as senior officers and/or directors of CHS, the Individual Defendants had knowledge of the details of CHS's internal affairs and core operations.

365. Lead Plaintiff and the Class have suffered damages in that, in reliance on the integrity of the market, they paid artificially inflated prices for CHS common stock. Lead Plaintiff and the Class would not have purchased CHS common stock at the prices they paid, or at all, had they been aware that the market prices were artificially and falsely inflated by Defendants' misleading statements. The market price of CHS common stock declined sharply upon public disclosure of the facts alleged herein to the injury of Plaintiff and Class members.

366. By reason of the conduct alleged herein, Defendants knowingly or recklessly, directly or indirectly, have violated Section 10(b) of the Exchange Act and SEC Rule 10b-5 promulgated thereunder.

367. As a direct and proximate result of Defendants' wrongful conduct, Lead Plaintiff and the other members of the Class suffered damages in connection with their respective purchases and sales of the Company's securities during the Class Period.

COUNT II

Against the Individual Defendants for Violations of Section 20(a) of the Exchange Act

368. Lead Plaintiff repeats and realleges each and every allegation contained above as if fully set forth herein.

369. During the Class Period, the Individual Defendants participated in the operation and management of CHS, and conducted and participated, directly and indirectly, in the conduct of CHS's business affairs. Because of their senior positions, they knew the adverse non-public information about CHS's misstatements concerning CHS's improper admission practices and unsustainable operating strategy.

370. As officers and/or directors of a publicly owned company, the Individual Defendants had a duty to disseminate accurate and truthful information with respect to CHS's business practices, financial condition and results of operations, and to correct promptly any public statements issued by CHS that had become materially false or misleading.

371. Because of their positions of control and authority as senior officers, the Individual Defendants were able to, and did, control the contents of the various reports, press releases, and public filings that CHS disseminated in the marketplace during the Class Period, as well as statements made during earnings and securities and healthcare analysts conference calls. Throughout the Class Period, the Individual Defendants exercised their power and authority to cause CHS to engage in the wrongful acts complained of herein. The Individual Defendants therefore, were "controlling persons" of CHS within the meaning of Section 20(a) of the Exchange Act. In this capacity, they participated in the unlawful conduct alleged which artificially inflated the market price of CHS securities.

372. Each of the Individual Defendants, therefore, acted as a controlling person of CHS. By reason of their senior management positions and/or being directors of CHS, each of the Individual Defendants had the power to direct the actions of, and exercised the same to cause, CHS to engage in the unlawful acts and conduct complained of herein. Each of the Individual Defendants exercised control over the general operations of CHS and possessed the power to control the specific activities which comprise the primary violations about which Lead Plaintiff and the other members of the Class complain.

373. By reason of the above conduct, the Individual Defendants are liable pursuant to Section 20(a) of the Exchange Act for the violations committed by CHS.

PRAYER FOR RELIEF

WHEREFORE, Plaintiff prays for judgment against Defendants as follows:

A. Declaring this action to be a proper class action pursuant to Rule 23 of the Federal Rules of Civil Procedure;

B. Requiring Defendants to pay damages sustained by Plaintiff and the Class by reason of the acts and transactions alleged herein;

C. Awarding Lead Plaintiff and the other members of the Class pre- and post-judgment interest, as well as their reasonable attorneys' fees, expert fees, and other costs; and

D. Awarding such other equitable and injunctive relief as this Court may deem just and proper.

DEMAND FOR TRIAL BY JURY

Pursuant to Rule 38(b) of the Federal Rules of Civil Procedure, Lead Plaintiff demands trial by jury of all issues that may be so tried.

Dated: July 13, 2012

LOWEY DANNENBERG COHEN & HART, P.C.

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APPENDIX K

UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF TENNESSEE

NORFOLK COUNTY RETIREMENT SYSTEM, individually and on behalf of all others similarly situated, *Plaintiff*, v. COMMUNITY HEALTH SYSTEMS, INC., WAYNE T. SMITH and W. LARRY CASH, *Defendants*.	CONSOLIDATED CIVIL ACTION NO.: 11-cv-0433 CLASS ACTION JUDGE ALETA A. TRAUGER MAGISTRATE JUDGE JOE B. BROWN JURY TRIAL DEMANDED
THIS DOCUMENT RELATES TO ALL ACTIONS	

FIRST AMENDED AND CONSOLIDATED CLASS ACTION COMPLAINT

TABLE OF CONTENTS

PAGE

OVERVIEW OF THE CLAIM.....1

CHS'S SCHEME TO DRIVE UP REVENUE 7

A. The Blue Book.....7

B. Pro-MED 12

C. CHS Tracked Physician's Admission Rates and Enforced Hospital Admission Benchmarks 16

D. CHS Terminated "Low Admitters" 18

E. CHS Also Used Hospitalists to Increase Admissions 20

F. CHS Paid Incentives for Admissions 21

G. CHS's Success in Boosting Admissions 22

H. Smith and Cash Omitted the Substantial Risk of Medicare Fraud.....26

JURISDICTION AND VENUE 32

PARTIES 32

A. Lead Plaintiff.....32

B. Defendants.....33

ADDITIONAL SUBSTANTIVE ALLEGATIONS 37

A. CHS Developed a Corporate Culture Centered Around Boosting Admissions 37

B. CHS Ignored Patient Safety and Medicare Rules In Order to Boost Its Revenue 40

C. CHS's Undisclosed Practices Increased Patient Admissions Improperly 45

1. CHS Systematically Used the Blue Book's "Admissions Justifications" To Boost Medicare Revenues Despite a Lack of Medical Necessary 45

a) Chest Pain 46

b) Syncope or Pre-Syncope 50

c) Community Acquired Pneumonia ("CAP") 52

d) Cellulitis 53

D. CHS's Admission Rates Diverge Dramatically From Its Competitors 54

E. Lead Plaintiff's Statistical Evidence Confirms That CHS's Strategies Worked 55

1. CHS's Observation Rate vs. Industry 56

2. CHS's Observation Rate vs. Average Of High Quality Systems 57

3. CHS's Observation Rate vs. Rural Hospitals in Same Geographic Area..... 57

4. Disproportionate Share of CHS's Admissions are "One-Day Stays"..... 58

F. CHS's Improper Admissions Practices Significantly Inflated Its Revenues 60

G. Additional Facts Support a Strong Inference of Scienter..... 60

1. Defendants Drove Up Admissions to Satisfy Analysts and Increase CHS's Stock Price 61

2. CHS's Top-Down Reporting and Monitoring Structure Supports a Strong Inference of Scienter 62

3. Judge Nixon's Rulings Find A Strong Inference of Knowledge..... 63

4. Smith's and Cash's Participation and/or Knowledge..... 64

5. Smith and Cash Ignored Potential Medicare Violations..... 67

6. Smith and Cash Personally Profited by Selling their CHS Stock at Inflated Prices 71

7. Smith's and Cash's False Denials and Dissembling of the Facts Underlying Tenet's Claims Support a Strong Inference of Scienter 73

H. Defendants' Additional Material Misstatements and Omissions During the Class Period 78

CLASS ACTION ALLEGATIONS 125

NO SAFE HARBOR 128

CLAIMS FOR RELIEF 129

COUNT I: Against All Defendants for Violations of Section 10(b) and Rule 10b-5 Promulgated Thereunder 129

COUNT II: Against the Individual Defendants for Violations of Section 20(a) of the Exchange Act 130

PRAYER FOR RELIEF 132

DEMAND FOR TRIAL BY JURY 133

1. Lead Plaintiff, the New York City Pension Funds, for its First Amended Consolidated Class Action Complaint (the "Complaint"), alleges the following upon personal knowledge as to itself and its own acts, and upon information and belief based upon the investigation made by and through its attorneys as to other matters. Lead Plaintiff's investigation included, *inter alia*, a review and analysis of: (a) documents produced by Community Health Systems, Inc. ("CHS" or the "Company") to the Department of Justice ("DOJ"), the Securities and Exchange Commission ("SEC"), and plaintiffs in *In re Community Health Systems Inc. Shareholder Derivative Litig.*, No. 3:11-0489 (M.D. Tenn.) (the "*Derivative Action*"), respectively; (b) documents pertaining to CHS and its senior executive officers and directors, including filings with the SEC and the DOJ; (c) analyst reports concerning the Company; (d) transcripts of CHS's earnings conference calls and investor presentations; (e) an expert statistical analyses performed using the Center for Medicare and Medicaid Services ("CMS") database; (f) analyses by a healthcare ethicist; and (g) the proceedings in *Tenet Healthcare Corporation v. Community Health Systems, Inc., et al.*, 11-cv-00732-M (N.D. Tex.) (the "*Tenet Litigation*").

OVERVIEW OF THE CLAIM

2. This is a securities class action brought on behalf of all persons or entities who purchased and/or sold the publicly traded securities of CHS from July 27, 2006 through October 26, 2011 (the "Class Period") against CHS and its senior officers, CEO and Chairman of the Board, Wayne T. Smith

("Smith") and CFO and Director W. Larry Cash ("Cash"), for violations of Sections 10(b) and 20(a) of the Securities Exchange Act of 1934 (the "Exchange Act"), 15 U.S.C. §§ 78j(b) and 78t(a), and SEC Rule 10b-5. Lead Plaintiff seeks recovery of monetary damages exceeding $891,000,000 plus prejudgment interest accruing from the filing of the initial class action on May 9, 2011.

3. This class action was precipitated by disclosures made publicly for the first time by Tenet Healthcare Corporation ("Tenet") in a complaint against CHS filed April 11, 2011. Tenet, a competitor hospital owner, revealed that CHS's successful track record of increasing revenues at other acquired hospitals was attributable to unsustainable Emergency Room ("ED" or "ER") patient admissions practices that CHS employed to improperly drive-up revenues. Improperly boosting inpatient admissions generated more Medicare revenues for CHS than discharging patients or treating them in observation status.

4. These improper and concealed practices included an edict for "ZERO" observations for Medicare patients through the use of aggressive admission justifications known as the "Blue Book" (emphasis added); and programming the "Pro-MED" software system used in CHS's ERs to prompt patient admissions to boost revenues. CHS implemented bonus programs; admission rate quotas approaching 50% for Medicare (over 65 years old) patients; messaging; and terminations to compel CHS personnel to adhere to the Company's aggressive admissions justifications.

5. Defendant Cash emphasized that hospitals must generate admission volume "to meet analyst's earnings expectations and impact CHS's stock price favorably." Increasing the Company's market capitalization facilitated CHS's growth-by-acquisition strategy by increasing the value of CHS's stock thereby facilitating CHS's ability to issue higher levels of debt to support additional acquisitions. Moreover, boosting the stock price enabled Smith and Cash to personally profit from the exercise of vested options during the Class Period.

6. Smith and Cash were repeatedly warned that CHS's use of the Blue Book and "no observation" policy created a substantial risk of a Medicare fraud enforcement action. CHS's long-time Medicare consultant pointedly concluded that the Blue Book criteria: (1) "*lacks specificity, allowing all cases to be classified as inpatient*"; (2) *would likely be construed as "statistically biased"*; (3) *results in "overcertification of inpatient"; and* (4) *could be construed as "an avoidance of 'best practice.'"*

7. Moreover, the same consultant warned that the Blue Book's lack of specificity "precludes cases from undergoing secondary physician advisor review and ensuring appropriate physician documentation and valid certification." Defendants were expressly told these criteria, along with CHS's refusal to use observation status, presented a "clear medical necessity compliance risk.

8. Defendants actively misled investors about the reasons for CHS's success. Defendants touted the "consistent execution of CHS's centralized and standardized operating strategies," its "ED initiatives," and its hospital acquisition strategy as

key factors in growing its business. These statements were materially false and misleading in failing to disclose, *inter alia*, that these strategies depended in large part on utilizing aggressive non-industry admissions criteria that were unsustainable and a substantial Medicare compliance risk. Indeed, once Tenet revealed CHS's improper admissions practices, CHS was forced to concede that it had recently made the decision to discontinue the Blue Book. Lower patient admissions and ED revenues would be reported in October 2011 for the time being, but the truth was still vehemently denied and actively concealed by Defendants.

9. CHS's "admit" edict was also contrary to CHS's publicly touted "mission" of providing quality patient-centered healthcare. As found by an ethicist from the University of Tennessee College of Medicine,[1] a potential loss of income, peer esteem,

---

[1] E. Haavi Morreim, J.D., Ph.D. is a medical ethicist and a professor in the Department of Internal Medicine at the University of Memphis, Memphis, Tennessee. From 1993 until 2009, she was a professor at the Department of Human Values and Ethics at the College of Medicine, at the University of Tennessee Health Science Center, Memphis, Tennessee. Professor Morreim has contributed to hundreds of publications, including books, chapters of books, and journal articles about ethical questions in healthcare decision-making. For example, Professor Morreim's book entitled, "BALANCING ACT: THE NEW MEDICAL ETHICS OF MEDICINE'S NEW ECONOMICS," discusses how economic pressure on caregivers to be cost-conscious in healthcare decisions presents ethical challenges. Moreover, Professor Morreim served on the American Society for Bioethics and Humanities for four years (from 1992-1996). Professor Morreim also served on the Society for Bioethics Consultation Board of Directors from 1992 to 1995. She also served on the

staff privileges, one's job or even your entire practice group's contract, created powerful pressure at CHS to align medical staff's professional judgment with the hospital's financial interests, creating a conflict for doctors who were to act in patients' interests. Not only that, but over-admitting also compromised patient safety. CHS's reports demonstrate that 70% of "hospital acquired conditions" following admission were inflicted upon Medicare patients.

10. Defendants' representations that CHS hospitals were in substantial compliance with federal, state and local regulations and standards, were materially false and misleading in failing to disclose long-standing potential Medicare violations at numerous hospitals.

11. CHS made generalized risk disclosures that failure to comply with Medicare requirements could subject the Company to government fines, or change operations. However, these generic risk disclosures themselves were materially misleading in failing to disclose the specific, known compliance issues that created a heightened risk, often internally discussed, that CHS would be severely fined and required to change admission practices.

12. When Tenet's lawsuit exposed CHS's unsustainable practices, a key to its success as a hospital operator and acquirer, and CHS's newly-disclosed ongoing government investigations, CHS stock immediately plummeted $14.41, or nearly 36%. This statistically significant decline involved extraordinarily heavy trading volume exceeding 44

Ethics Committees of LeBonheur Children's Medical Center and the Regional Medical Center in Memphis.

million shares, reducing the Company's stock value by $1.3 billion in a single day.

13. By virtue of their participation in the implementation of the Blue Book, Pro-MED and enforcement strategies CHS used to drive admissions, and their "central" control and monitoring of CHS hospital admission practices and performance, Smith and Cash knew or recklessly disregarded material undisclosed facts about CHS's admissions practices which made their public statements about the source of CHS's success; its substantial compliance with Medicare regulations, and its central focus on quality healthcare; materially misleading. Significantly, over-admitting also compromised patient safety; CHS's reports demonstrate that 70% of "hospital acquired conditions" following admission were inflicted upon Medicare patients.

14. While in the possession of material, non-public information concerning impending revisions to the Blue Book which they knew would reduce ED admission rates, defendants Smith and Cash sold 980,000 CHS shares through the exercise of vested options in 2009 and 2010, reaping unlawful profits of $8,447,500 and $7,327,200, respectively.

15. Moreover, while conceding after Tenet's disclosures that CHS had started to discontinue using the Blue Book's admission criteria at its hospitals, Defendants falsely claimed that Tenet's allegations had no merit and that the switch to industry-compliant InterQual criteria would have no material impact on CHS's operations. Yet, CHS's experience internally showed precisely the opposite, *i.e.*, that admissions would suffer with the

abandonment of the Blue Book, and that CHS's undisclosed practices subjected it to a heightened risk of a regulatory investigations and fines.

16. By 3Q 2011, CHS's results left no doubt: the switch to InterQual resulted in a sustained and accelerating decline in admissions. After the close of business on October 26, 2011, CHS reported that the rate of "same store" admissions in 3Q 2011 had declined 7.0% as compared to 3Q 2010, when CHS used the Blue Book (the "October Disclosure"). This constituted a decline of 26,000 admissions for the nine months ended September 30, 2011. CHS's stock price dropped $2.32, or 12%, on October 27 to close at $17.81, a statistically significant decline on heavy trading volume.

17. The market, including CHS supporters such as Wells Fargo, recognized the 3Q results as a stark indication that Tenet's analysis of CHS's admissions practices was correct.

18. Wells Fargo downgraded CHS, explaining that "[o]ur prior view which was consistent with the Company's expectations had been that CYH's admission practices were in line with the industry and therefore would not change significantly. We believe this view is incorrect …. CYH's comments about weak admission trends because of the negative press could mean Tenet's claims have more validity than originally thought."

19. J.P. Morgan also found "it[] a bit more troubling … to see inpatient volume drops of this size" and raised questions about the Company's "continued stability" in light of ongoing investigations.

20. Consistent with the 3Q 2011 results, in July 2014, CHS settled the DOJ allegations that the Blue Book was a guideline for Medicare fraud for $98 million – one of the largest *qui tam* settlements in history. Shortly thereafter, CHS agreed to yet another $75 million settlement related to Medicaid fraud.

21. As part of the DOJ's settlement, CHS was also required to enter into a Corporate Integrity Agreement with the Department of Health and Human Services-Office of the Inspector General, to create a Medicare compliance program.

22. "This is the largest False Claims Act settlement in the district…" said David Riviera United States Attorney for the Middle District of Tennessee, on August 4, 2014. "[I]t reaffirms this office's commitment to investigate and pursue healthcare fraud that compromises the integrity of our health care system." Summing up, Rivera said, the DOJ "is committed to ensuring that … hospital providers do not engage in schemes to increase medically unnecessary in-patient admissions of government healthcare program beneficiaries in order to increase profits."

23. Reflecting on the ethical problem with CHS's conduct, DOJ's U.S. Attorney Anne M. Tompkins of the Western District of North Carolina added: "Health care providers should make treatment decisions based on patients' medical needs, not profit margins …. We will not allow this type of misconduct to compromise the integrity of our health care system." Inspector General David R. Levinson, further explained that "a rigorous multi-year Corporate Integrity Agreement requiring that

the Company commit to compliance with the law, [will] ensure the Company's fraudulent past is not its future."

CHS'S SCHEME TO DRIVE UP REVENUES

A. The Blue Book

24. CHS's scheme centered on driving up inpatient admission because Medicare pays more for inpatient treatment than for an ED patient placed in observation or discharged. The strongest push to admit was for patients in "soft" diagnostic categories (*e.g.*, chest pain, abdominal pain, and syncope). Michael Miserocchi ("Miserocchi"), Group Operations V.P. and Senior Director of ED Programs, who was responsible for Pro-MED integration at all CHS hospitals, reminded hospital CEOs that ED admissions increased revenues:

> every admission is worth approximately $5800 in net revenue, and every patient discharged home is worth approximately $250 in net revenue. You can pay for a locums [temporary] physician very quickly with admissions, ancillaries, supplies and procedures generated by patients that are kept in CHS hospitals.

25. Similarly, Carolyn Lipp ("Lipp"), Senior Vice President of Quality and Resource Management ("QRM"), who directly worked for and had "the eyes and ears" of CEO Smith, highlighted in a 2008 presentation that the maximum reimbursement for observation status was only $661; in contrast, Medicare reimbursed hospitals as much as $7,000 more for some medical conditions when the patient is

admitted to the hospital,[2] and paid an average reimbursement of $4,000 to $5,000 higher when patients were admitted rather than placed in observation care. In one 2006 presentation, Lipp touted the 12-month Company-wide revenue impact from using the Blue Book capturing what would otherwise be "missed admits" exceeded $140 million.

26. Starting in 2000, CHS developed and implemented the "Blue Book;" a compendium of liberal admissions criteria contrary to widely-accepted medical criteria. No other hospital chain in the U.S. used the Blue Book. For years the Blue Book had no symptoms that indicated "observation treatment." The Blue Book did not list an objective treatment criteria but a series of "Admission Justifications," to trigger the medical staff to admit patients who otherwise could have been placed into observation and/or released. With it, CHS hospitals maximized admissions to charge Medicare more money for services than medically necessary.

27. In contrast, over 75% of U.S. hospitals utilized independent, third-party admissions criteria provided by InterQual or Milliman, which are based upon objective, clinical results. InterQual was developed by an independent panel of 1,100 physicians and medical providers, contains over

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[2] Zach Gaumer & Dan Zabinski, Medicare Payment Advisory Comm'n (MedPAC) Presentation, Recent Growth in Hospital Observation Care, *available at* http://www.medpac.gov/documents/september-2010-meeting-presentation-recent-growth-in-hospital-observation-care.pdf?sfvrsn=0. MedPAC is an independent Congressional agency that advises the U.S. Congress on issues affecting the Medicare program.

16,000 references to medical sources, and was used by 3,700 hospitals across the country, over 300 health plans and CMS. Similarly, the Milliman Care Guidelines, which have more than 15,000 medical references and are used by over 1,000 hospitals, were developed by an experienced team of physicians and reviewed by approximately 100 independent doctors.

28. Prior to and until the Tenet lawsuit, CHS, at Smith's direction, mandated that the Blue Book be used at all hospitals for patient intake. A PowerPoint presentation titled "CHS Clinical Guidelines," dated February 4, 2004, prepared by Lipp and approved by Smith, set forth the company-wide protocol applicable to all CHS hospitals: "All physicians should receive a copy of the Blue Book"; "each case manager should carry one with them"; an "[e]lectronic version should be available in ER," and applicable admission criteria should be placed on the bedside hospital record of every ED patient for review by ER nurses and physicians. Moreover, Smith and Cash approved the "ED Quality Project Action Plan" in August 2006 that established the admission practices protocol CHS hospitals were required to follow. As part of the indoctrination, CHS trained all ED staff, including ER physician groups and case managers, on the use of its Blue Book.

29. The Company assured admissions using the Blue Book by implementing a "ZERO Medicare observation" policy. With no mention of observation; observation status was not presented as an option to ED physicians trained on the use of the Blue Book criteria. Lipp put the matter bluntly: "[w]e want to avoid observation as much as possible on Medicare patients and on private insurance," and issued a

directive to hospital case managers – "no chest patients in observation" – rather, all such patients were to be admitted.

30. In a training presentation titled "Observation Status and One-Day Stays, What You Need to Know," Lipp, Smith's and Cash's senior report, proclaimed that with "tighter Observation management," hospital "Medicare One-day Stay percentage[s] will probably increase." She also emphasized that "Case Management is the key to controlling use of Observation status," and required that "case management **MUST BE NOTIFIED** of every Observation case and **MUST APPROVE** the use of observation before the patient is placed into Observation status" (emphasis in original).

31. Based upon these directives, case managers understood that the Blue Book "required" inpatient admission of all chest pain complaints. The ED Medical Director at Gadsen Regional Medical Center (AL) stated that it was the "CHS way" to admit "just about all our chest pain to impatient status." In January 2009, Gadsen's Director of Health Information Management candidly expressed her concerns to CHS corporate that she "was scared to death that we are going to see some huge repercussions financially if we maintain these practices."

32. CHS laid the responsibility for patient admissions squarely on each hospital's CEO, who aggressively implemented these corporate directives. For example, in Berwick Hospital's "Action Plan" for 2Q 2006, CEO Steve Grubbs advised corporate that the "CEO, ER Director and ER Physician will work

toward a "goal of ZERO Medicare observations." Grubbs set out the following action steps:

- "The CEO and ER Director will immediately implement the Blue Book Plan or other plan aimed at better identification of admission criteria though the ER."
- "The ER Director will immediately implement a process that requires the CEO to be personally called for approval for EVERY requested admission into observation."
- "The ER Director implement immediately a process that requires that the CEO or Administrator on c all be contacted when any patient that meets Blue Book or other criteria is not admitted by either the attending physician or ER physician."
- "The ER Director will immediately implement a process that will require contacting of the attending physician for 70% of every patient over age 65."
- "Physicians that have experienced volume downturns will be scheduled a personal office visit from a member of the hospital administrative team."

33. Phoenixville Hospital's (PA) CEO reported to Division III President Gary Newsome and other executives on March 9, 2007, that he was "in the ER throughout the day (including weekends)" and made sure ER physicians' "'marching orders' are to admit." Vista Health (IL) reported to Smith, Cash, and Division I President Tom Miller that the CFO and Case Management Director were "reviewing daily

observations that can convert to admissions [which were] [d]iscussed daily at flash meeting." Bradley Memorial Hospital (CT) calculated that "[c]onversion of ED observation to acute admit will result in potential annualized increases in NR [net revenues] of $940K to $1,410K."

34. When the CEO of White County Community Hospital (TN) was confronted with performance below CHS's benchmark admission percentage, he vowed to "get[] the current ED physicians in line as well as recruit[] replacement physicians who understand the expectations we have for our patients. We will get this back on track." Vista Health reported to Smith, Cash and Tom Miller in its December 2008 Operations Review that it was "[e]valuating physicians on duty in the ER and their percentages [21% admit rate] in accordance to CHS blue book."

35. In April 2006, the Sunbury Community Hospital CEO thanked Group III VP Marty Smith "for the accolades on our conference call for the ER admit percentage. We have really just aggressively implemented the Blue Book …. I guess in final analysis I'm just doing what Group 3 has pushed from day one. The real credit goes to Deb and her ER team-they've taken something completely new to them and done an excellent job at implementing the process and enforcing the procedures." In January 2007, when the "admit percentage in the ER [fell] tremendously low," the CEO advised corporate that "I met with 2 ER docs … I may be letting one of the physicians go if we cannot maintain an appropriate level."

B. Pro-MED

36. CHS's headquarters pressured the Division Presidents, who in turn pressured hospital CEOs and administrators to meet admission benchmarks tracked by Pro-MED. Pro-MED is a proprietary networked software system used to track, in real time, patient, ED and individual physician statistics, and uses a "scorecard" to compare them.

37. CEO Wayne Smith directed all CHS hospitals, including newly-acquired Triad hospitals, to utilize Pro-MED to increase admissions rather than observations. The main reason for the Pro-MED deployment was due to concerns regarding "07 hospitals [*i.e.*, newly-acquired Triad hospitals], ED admission rates being 1.2% below CHS Legacy," which translates into "approximately $40 million annually in net revenue."

38. Smith boasted that with Pro-MED "over the last 4 or 5 years, we've been able to increase our admission rate by about 10% in our emergency rooms." Smith failed to disclose the material fact that Pro-MED was increasing the admission rate by a means that would not bear regulatory scrutiny.

39. CHS senior executives mandated that Pro-MED be installed in every ED, "Standardize at every hospital; Lock out [hospital physicians from making] changes." On August 2, 2006, Michael Portacci ("Portacci"), then senior vice president of Group II Operations,[3] sent Group II hospital CEOs a revised "ED Project Immediate Action Plan," copying Smith,

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[3] Portacci later became the President of Division II.

Cash, Lipp and the Group Management Staff. CHS directed the CEOs to implement the following protocol:

* * *

I. Pro-MED Reports

- All hospitals will fully utilize Pro-MED capabilities, *i.e.*, test mapping, interfaces, status boards.
- Pro-MED reports are to be reviewed by the ED Medical Director to identify patterns of problems among ED doctors. These patterns are to be reported to the CEO weekly.
- If patterns are identified with any one doctor, he/she should be counseled, then reevaluated. If there are issues with more than one doctor, the ED group should be evaluated for continued use.

* * *

II. CEO Accountability

- Spend minimum of 1 hour per day in ED and focus on doctors, patients in waiting room, and registration.
- CNO spend minimum of 1 hour per day in ED (different hour from CEO) and focus on triage, nurse staffing, cleanliness, throughout, processes, and use of Pro-MED.
- Continue daily ED team meetings.
- CEO to submit weekly checklist/attestation to Group office regarding ED management.

III. Group Meetings

- Each Group will hold a meeting with CEOs, CNOs, ED Medical Directors, and ED Nurse Managers within the next 30-45 days to discuss review project findings and corrective actions.

40. Portacci also provided Group II CEOs an updated "comprehensive ED checklist" that required them to report on the status of numerous action steps; for instance:

- Review Pro-MED reports (census summary, physician activity and quality review) – executive team member ownership.
- Verify [Pro-MED] test mapping is active and used during triage – daily.
- Assure Blue Book utilization and review log – daily.
- Attending [physicians] called on at least 70% of patients over 65 – daily.
- Attending [physicians] called on at least 30% of all patients – daily.
- Medicare ER admission trend being monitored, positively trending to meet goals of 35-40%.
- Admission rate being monitored, benchmark against PY [prior year] actual.

41. A September 25, 2007 internal memo addressed to Cash described the Pro-MED Standardization Initiative as "a multi-pronged activity affiliated with our same-store hospitals. It includes workstations for each ED bed … and re-

implementation of the standard system configuration (Chief Complaint, Assessment Questions, Test Mappings) in each market." Test mapping involved "standardizing a set of minimum tests that are required for patients with certain chief complaints."

42. At Smith's direction, the tests ordered for each medical condition were determined, or "locked down," at the corporate level. A September 2007 internal memo sent to CHS executive officers explained that once the test mapping feature was finalized and implemented, "the future maintenance of [test mapping] will occur centrally by CHS Corporate." Those at the hospital level that wished to make changes to the test-mapping feature were required to submit a change request.

43. At Smith's further direction, corporate also tracked hospitals' levels of Pro-MED corporate "standardization" and "how compliant [] ED docs are with the Pro-MED system recommendations for admission."

44. Pro-MED's QualCheck feature was also installed in some hospitals. QualCheck identified patients with an "alert" or "flag" in the patient's record, which required tests or treatment before the flag could be removed. Physicians who decided to discharge patients despite the flags were required to actively override QualCheck. CHS used Pro-MED to identify and track any and all physicians who exercised that override. CHS stated that QualCheck's goal was to "pick up 2 or 3% increase in Inpatient Admissions." An August 1, 2007 email to Lipp, Sandy Carson, Debbie Cothern and Miserocchi stated that "QualCheck uses Blue Book criteria to identify patients requiring admission, it also alerts

the physicians to additional documentation needed to justify an admission for case management." A 2010 Pro-MED annual report described QualCheck overrides as "lost revenues."

45. In the 2006 Pro-MED Standardization report, Gary Seay, Vice President and Chief Information Officer, observed that "there is a correlation between the percentage of patients with quality review alerts who are discharged and the admission rate. Thus, if the admission rate is low, in most cases the number of patients with Quality Review alerts who are discharged is high."

46. Miserocchi pointed out to Marty Schweinhart, who reports directly to Smith, that performance metrics have been built into ED contracts with physician groups so that CHS could restrict the percentage of patients discharged with Pro-MED review flags to 35% of total visits.

47. Many CHS physicians were outraged that CHS used Pro-MED to supersede their independent medical judgment. In 2007, Dr. Torrence of Skyridge Medical Center wrote, "[t]o be frank, some of the indicators that Pro-MED flags in our Quality Review are ridiculous." An internal memorandum informed Cash that numerous physicians had questioned using "a tool like Pro-MED," and that "Pro-MED was not a good tool in anyone's eyes." An ED Director explained that physicians were "aggravated" by Pro-MED because they felt compelled to "justify their decision" to discharge patients. Lipp noted in an ED Quality Review report that "[p]hysicians [are] not accepting automated orders in Pro-MED."

48. Physicians also found that Pro-MED's test-mapping component compromised patient safety. On August 30, 2007, Director of Quality Assurance at Watsonville Community Hospital, Michael McGannon, informed CHS senior management that Pro-MED's standardized test mapping "subject[s] patients to unnecessary pain, radiation and expense … The blanket use of these several tests is contrary to the standard of care. Expecting the triage staff to manipulate chief complaint designations to get around ordering inappropriate tests is, in itself, inappropriate." Despite these physician concerns with Pro-MED, CHS mandated that Pro-MED be installed and used in every hospital and controlled from corporate headquarters.

49. Similarly, on September 30, 2007, the ED Medical Director of Easton Hospital (PA) reported to CHS corporate that "[t]he diagnostic tests that are currently being used as the default standards by Pro-MED do not meet the standard of care for emergency medicine."

C. CHS Tracked Physician's Admission Rates and Enforced Hospital Admission Benchmarks

50. CHS's headquarters pressured Division heads who, in turn, pressured hospital CEOs and staff to use the Blue Book to meet admission benchmarks tracked by Pro-MED. In an August 2, 2006 memorandum titled "ED Initiative & Follow-up," Portacci attached an "ED Project Immediate Action Plan." The Action Plan instructed the CEOs that "Pro-MED reports are to be reviewed by the ED Directors to identify patterns of problems among ED doctors … [I]f patterns are identified with any one

doctor, he/she should be counseled, then re-evaluated. If there are issues with more than one doctor, the ED group should be evaluated for continued use."

51. Portacci, now President of Division II Operations, emphasized to Division II's hospital CEOs and officers: "there continues to be opportunity with your daily/weekly management of the ED patients and patients in the 65-older category continue to run well below the benchmark. Other Division Presidents did the same.

52. CHS's hospital CEOs responded to the pressure from headquarters by applying pressure on ED physicians. Lock Haven Hospital, (PA), for example, implemented daily "flash meetings" and produced a "Score Card" to show that they were keeping up with Pro-MED benchmarks. Every morning the CEO, CNO, CFO, and ER nursing director would meet to discuss ER visits and admissions statistics.

53. Gateway Medical Center, Tennessee, CEO Tim Puthoff reported, "We continued to meet weekly with ER physicians to implement Pro-MED (2/1/08) and Blue Book (11/1/07)." Vista Health reported to Smith, Cash and Tom Miller in its December 2008 Operations Review that it was "[e]valuating physicians on duty in the ER and their percentages [21% admit rate] in accordance to CHS blue book."

54. Maureen Bodine, Chief Nursing Officer of Barstow Community Hospital wrote to Michael Miserocchi, "My nurses think I have a screw loose because we are insisting they call all over 65… I know that increased calls to physicians could lead to

increased admissions but I am having a hard time with this one too… I think physicians should be called on patients who meet admission criteria, not clinic type stuff….” Staff members viewed these tactics as “arrogant[]” and a “heavy handed attempt [to get physicians] compliant” with Pro-MED benchmarks.

55. Maggie Redmond (Director of Emergency Services at CHS corporate) advised CHS’s executives that CEO Tullman also “developed a contract addition for his ED physician group” titled “ED Physician Performance Criteria” mandating that the ED physicians and physician assistants “[m]eet or exceed the following specific [Pro-MED criteria] benchmarks.” Recognizing the widespread truth of this practice and that it posed regulatory compliance risks, Michael Miserocchi, CHS’s V.P. of Operations, cautioned Tullman that “[w]e have always been wary of putting this in writing.”

56. On August 1, 2007, CEO Butch Naylor at White County Community Hospital, addressed “the current freefall in our ED Admit rate,” and stated, “We are working on getting the current ED Physicians in line as well as recruiting some replacement physicians who understand the expectations we have for our patients.” (Emphasis added).

57. Weekly report templates called the “Comprehensive CEO Report” were emailed from CHS corporate to CEOs of numerous hospitals, listing various ER Action Plans:

> Assure blue book utilization and review log-daily

> Attending [physicians] called on at least 75% of patients over 65- daily
> Attendings called on at least 30% of all patients- daily
> Review Pro-MED reports (census summary, physician activity and quality review) - daily
> CNO report to CEO

58. The "2010 Strategic Business Plan" for Woodland Heights Medical Center, set the "Goal": a "19% admission rate"; "Increase admissions on patients over the age of 65"; and, "Focus on case management in the ED to reduce wait times, increase admission rates."

59. That CHS's Blue Book driven admissions practices were having the intended effect was clearly evidenced by the fact that un-indoctrinated temporary physicians, known as *locum tenes* physicians, admitted patients at a much lower rate than CHS's regular physicians. One hospital blamed low monthly admissions statistics on the use of a "*locum tenes* physician who only had one admission out of 26 patients."

D. CHS Terminated "Low Admitters"

60. ED physicians who failed to improve their admit rates were either terminated, replaced, or had their shifts reduced. The following are just some of the documents that exemplify how CHS treated physicians who did not follow the "admit" mantra:

- following a 13% decline in admissions, the Action Plan for SkyRidge Medical Center (OH), dated August 12, 2008, was to "*Eliminate ED physician low performers*;"

- Longview hospital (TX) Group Vice President, Tim Adams, reported to Portacci that Longview identified a variant ED Physician last month and "he was removed;"
- in a Site Visit Summary of Lock Haven Hospital (PA), Miserocchi noted that a physician with admission rates in single digits was going to be "transitioned from the schedule." At that same hospital, CHS terminated Dr. Querci, and considered replacing Dr. Gingrich and Dr. Herberg, for consistently falling below admission benchmarks for patients over 65 years old;
- Division III President, Gary Newsome was advised that since Dr. Farooi, a member of the active staff, who did ER relief, "admitted at a 50% rate during his one shift on 9/4[05] … we will find another physician to fill those relief shifts;"
- Division V President, Thomas Miller, was advised in June 2009 that a "low admitter [at Parkway Regional Hospital] was taken off [the] June schedule;"
- CHS executives pushed the Haywood Park Community Hospital ED physician group to "address the one physician who lags in support of admissions to the facility"; and
- at Berwick Hospital, at least one ED physician (Dr. Merriweather) had his shifts reduced because he was deemed to be a "chronic low admitter."

61. Smith boasted to stockholders that "we have successfully fulfilled our mission to enhance the

level and quality of care," but failed to advise investors that CHS was prepared to, and did replace, entire ED physician groups for low ED admission rates. A December 11, 2009 memorandum, concerning a site visit to South Texas Regional Medical Center (TX) explicitly states: "Emergency Department Contract .... They will be terminating their agreement with Atascosa County Emergency Physicians .... *The percent of admissions thru the Emergency Department continues to be below benchmark and prior year*. . . Therefore, the contract will be terminated and a new group brought in." (Emphasis added).

62. Smith and Cash kept tabs on CEO's push for admissions including at South Texas Regional Medical Center. The memo quoted above on physician terminations due to low admissions was forwarded to defendants Smith and Cash with the handwritten notation, "New CEO is doing very good job."

63. A Division IV Volume Variance Analysis (vs. PY), Projected as of February 11, 2010, reported that Spokane/Deaconess was down … 88 ED admissions "due to soft volumes and low admit rate (12.8% vs. 15.5% PY); ED group change out complete as of Feb 10."

64. In an August 9, 2009 email to Division IV President Bill Hussey, a Hospitalist at Alta Vista Regional Hospital complained that "[w]e have been advised by the CEO that we should 'admit' no matter what. This is against the law and can be evaluated by both [M]edicare and [Medicaid] since it comes close to fraud … I know that the ED personnel get paid a bonus in the form of a 'risk pool' for

admissions and consultations. The more they get, the more the bonus. This is a fact, thus the push for admissions that are really unnecessary or not substantiated." Upon information and belief, Hussey forwarded this complaint to CHS's Compliance Officer, Andi Bosshart, who reported directly to Smith.

65. As found by a medical ethicist expert, CHS's "admit" edict was inconsistent with CHS's publicly touted "mission" of improving the quality of healthcare provided. The potential loss of income, peer esteem, staff privileges, one's job or even one's entire practice group's contract, created powerful pressure to align one's judgment with the hospital's financial interests, at the expense of patients' interests.

E. CHS Also Used Hospitalists to Increase Admissions

66. CHS also created a "Hospitalist Program," which made their goal clear; as Miserocchi stated, "hospitalists should be…increasing admissions." In a March 16, 2011 memorandum to Michael Portacci, Rob Horrar, VP of Operations for Division II, proposed placing a hospitalist at Abilene Regional Hospital to drive up admissions from a 10% to a 16% benchmark.

67. Similarly, in a May 31, 2010 "Trip Report" concerning Harris Hospital (TX), the VP of Division II Operations, Michael Garfield, advised Portacci that "[w]ith the volume decline thus far for 2010, it is essential to have a 24/7 Hospitalist arrangement set up as quickly as possible."

68. A spreadsheet titled Weekly Volume Variance (Division IV) dated February 28, 2010 states:

> Had the National Medical Director of our Hospitalist Group on site this week to *re-educate the Hospitalists on admission expectations* and expectations for preformance [sic] improvement. *He was notified that if immediate improvement was not seen that the contract would be terminated*. ED Physicians and ED Staff was notified that if they have a patient that meets admission criteria and the hospitalist refuses to admit, that the CEO was to be notified. …. (Emphasis added).

F. CHS Paid Incentives for Admissions

69. CHS provided monetary incentives to its employees at all levels of its hospitals to systematically boost ED admission rates.[4] According to a 2004 Incentive Bonus Plan, "[i]mprov[ing] ER Admit rate by .3% over 2003" was equivalent to 2% of the bonus; by 2010 the bonus increased to 3%.

70. Inconsistent with its patient centric improved quality of care statement, CHS paid bonuses to hospital CEOs to admit more non-self-pay ED patients. For example, "Wayne Smith and Larry Cash ... approved a 4Q 2007 CEO admission incentive" after "discuss[ing] significant ED admission opportunities." The "4th Quarter Performance Plan" provided CEO bonuses of "10% of

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[4] When physicians reached the CHS benchmarks, CHS corporate would take special notice, thanking a physician for generating the highest increase in admissions for the month.

his 4th quarter salary" for meeting "non-self-pay admission goals." This practice made CHS's representation about is patient-centric improved quality of care materially false and misleading because over-admitting also compromises patient safety; CHS's reports demonstrate that 70% of "hospital acquired conditions" following admission were inflicted upon Medicare patients.

71. The ED physicians themselves also received additional compensation for admitting patients more aggressively. A 2010 Weekly Management Report for Cherokee Medical Center provided to Miller states:

> I feel very good about the incentive plan we have put into place for our ER physicians … and it seems to be having a positive effect. This marks the 3rd year in a row that CMC has rolled out an incentive plan based on certain Pro-Med metrics. …. Some say "*what gets rewarded, gets repeated*," and we have found this to be true with our ER incentive plan. ER performance has been consistently good MTD. A dmission percentage increased 1.3% compared to PY and 1.2% compared to PM. …. ER admission percentage over the last 6 months: August – 8.5%, September – 9.0%, October – 7.0%, November – 9.1%, December – 10.4%, January MTD – 12.9%.

72. However, if a physician failed to meet CHS's admission benchmarks, their incentive plans would suffer. For example, Dr. Bostick at Springs Memorial Hospital was branded a "low admitter" and, as a result, CHS revised his incentive plan.

G. CHS's Success in Boosting Admissions

73. CHS's standardization and centralization of ED strategies using the Blue Book's liberal, non-industry standard criteria, proved highly successful in increasing admissions regardless of medical necessity. A Division II "Executive Summary-September 2008" from President Michael Portacci to the Division II "Chief Officers," attached a Consolidated Pro-MED Report covering 51 separate metrics. The report indicated that for the nine months ended September 30, 2008, 43,009 patients were admitted while only 736 were placed in observation. A separate table captioned "Patients 65 yrs. or Older Report," reported 2,511 admits out of 6,322 total patients seen in the ED, or 39%, as compared to 23 patients in observation, or 0.4%.

74. The impact of CHS's practices is starkly illustrated by CHS's 2007 acquisition of approximately 50 Triad Hospitals, Inc. ("Triad"). The Blue Book was the centerpiece of CHS's acquisition strategy whereby patients previously treated at Triad Hospitals in Observation would now be treated as inpatient admissions. CHS's senior management saw a huge financial opportunity in applying this strategy to Triad. Miserocchi estimated the impact on admissions at "approximately $40 million annually in net revenues."

75. CHS senior management was well aware that Triad hospital CEOs were resistant to use of the Blue Book. On July 30, 2007, Dr. Barbara Paul, CHS's Chief Medical Officer, who reported directly to Smith, and a member of the PAB and CHS's Management Committee, summed up the concerns at the hospitals, as follows:

> "Blue Book just not adequate. They need InterQual to succeed in the conversations they have [with] insurers. Now that Co has increased so much in size, and now that it is likely that many 'CHS07' [Triad] hospitals already subscribe to InterQual, the group felt it was time to revisit this whole issue and see what makes sense going forward."

76. Despite the serious compliance risks, Smith and Cash refused to discontinue the Blue Book which was a central component of CHS's acquisition and revenue strategies. In fact, Smith, with Lipp, personally took the lead on developing and overseeing ED training on the Blue Book, and were widely successful. On October 3, 2007, Lipp advised her colleagues that this issue was "discussed at every Regional [Physician Advisory] PA meeting and that on October 2 she and Defendant Smith "made the rounds of all the [CHS] division meetings and discussed the issue because it is a high priority for us with the CHS 07 hospitals."

77. In one of Lipp's corporate presentations, titled "Observation Status and One-Day Stays, What You Need to Know," Lipp described, among other things, how Brownwood Regional Medical Center (TX), a former Triad hospital, had implemented CHS's "Observation Initiative." Following this protocol over a 10-week period between August 29, 2007 and October 31, 2007, Brownwood reduced weekly observation rates from 20% to 3%.

78. To achieve this dramatic reduction, Lipp stated that CHS directed the following actions at Brownville:

- "Retrained ED case managers [CM] and physicians … on the Blue Book."
- "Reviewed case manager's ED logs to see if there would have been changes in admission status using the new training [*i.e.*, Blue Book]."
- "Started flash meetings every morning and the CM Director made rounds between 7 am and 9 am ... any observation patients are reviewed in flash meeting and the Director calls the physicians to review those cases."
- "Admission unit allows CM [case manager] to review all inpatients prior to going to the floor.
- "CM dept. accountable to Admin Team [CEO, CFO, CNO] every day for any OBS admissions."
- "Staff was awarded with pizza party for reductions in observations."

79. Similarly, David Whittaker, Regional Director of QRM, on October 31, 2007, told the CEO at Greenbrier Valley Medical Center (a former Triad facility) and Division III President Gary Newsome that:

> it is important to start using the CHS 'Blue Book' admission criteria as soon as possible. A n exercise during our discussions using existing medical records of both inpatient and observation patients evidenced that most of the observation patients in the exercise who had been admitted as outpatient observation status patients under the InterQual criteria would

> have been admitted as inpatients if the Blue Book criteria had been used. By switching to CHS [Blue Book] criteria, the hospital should experience a significant reduction in Medicare and other outpatient observation status patients and a significant increase in inpatient admission.

80. Greenbrier's 2008 Strategic Plan presented to Newsome and other executives followed CHS's directive in implementing Pro-MED and Blue Book, so the hospital would "[i]ncrease admission % from 12% to 16%," and account for $215,000, or 14% of the projected 2008 EBITDA increase.

81. Likewise, in late October 2007, Tim Adams, the Division II VP of Operations conducted a site visit of DeTar Hospital (Victoria, TX), another former Triad hospital, and sent an "ED Action Plan" to Portacci (Division II President), which was forwarded to Smith and Cash. The Action Plan detailed how DeTar "represents a significant opportunity to increase admissions based on patient meeting Blue Book admissions criteria."

82. Tenet's experts determined that in 2006—before the acquisition by CHS—Triad's observation rate of 11% was almost three times CHS's 4.1% observation rate. Under a standard two-tail t-test, CHS's divergence from the national average observation rate of 9.18% was statistically significant (p-values 0.05) (*i.e.*, extremely unlikely to have been the result of chance).

83. Within one year of CHS's acquisition of Triad, Triad's use of observation status decreased by 52% through the implementation of its Blue Book

admission practices (again a statistically significant result). Conversely, one year after the acquisition, the percentage of "one-day stay" admissions—which Medicare auditors consider to be potentially indicative of improper admissions—increased by one-third, with even higher increases for patients with common conditions such as chest pain, syncope, and GI-bleed. The difference in one-day stays at Triad from 2007 to 2008 is statistically significant, meaning that the difference is extremely unlikely to have been the result of chance. This dramatic swing toward one-day stays confirms the effects of using the Blue Book -- under CHS's direction, Triad hospitals were inappropriately admitting patients who should have been treated in observation status.

84. CHS actively misled investors about the reasons for CHS's success. Defendants consistently touted its "centralized and standardized operating strategies," and the synergies and operating efficiencies achieved in the Triad acquisition, while failing to disclose that its success was driven in large part by employing CHS's unique non-industry admission strategies to systematically turn patients whose medical needs likely required treatment in outpatient observation status into more lucrative inpatients.

85. Defendants' representations touting CHS's quality patient care were materially misleading in failing to disclose the Company's "admit" edict, which created a conflict for doctors who were supposed to act in the patients' interests. Moreover, CHS's representations about its quality patient care were materially false and misleading because over-admitting compromised patient safety; CHS's reports

demonstrate that 70% of "hospital acquired conditions" following admission were inflicted upon Medicare patients.

86. In sustaining claims based upon similar allegations in the *Derivative Action*, Judge Nixon found that Smith, Cash and other CHS Board of Directors members knew that "obtaining significant increases in admission rates … at Triad hospitals could not have been done without using improper means." *See* Order Granting in Part and Denying in Part Defendants' Motion to Dismiss dated September 27, 2013.

H. Smith and Cash Omitted the Substantial Risk of Medicare Fraud

87. CHS senior management was well aware from internal audit reviews and outside consulting experts that CHS's admissions policies created a substantial risk of a Medicare fraud enforcement action. In a February 2004 memorandum, Chuck Reece, QRM Regional Director, informed Lipp and head compliance officer, Andi Bosshart, of "evidence of a widespread trend of one-day stays" resulting from CHS's policy of "no Medicare observations" that posed a "significant potential compliance issue relating to the use of observation within our facilities." Lipp was a direct report to Smith (and Cash), as was CHS's head of Compliance.

88. Reece reported that "it was clearly communicated to me that the tracking of and response to reported observations made it clear to [hospital case management directors] that there was an expectation to have no Medicare observations …. All stated that they formed this perception based on

direct or indirect communications from CHS group and/or corporate staff." Case managers from both the Mid-Atlantic and Southeastern regions conveyed these same concerns to Reece.

89. CHS's QRM department subsequently prepared CHS's observation guidelines for inclusion in the Blue Book, which were presented to the Regional Physician Advisory Committee ("RPAC"). However, the RPAC rejected these guidelines on January 8, 2005 because "including observation guidelines in the Blue Book may prompt physicians to use the observation category instead of admitting the patient to inpatient status when possible." Further, "[t]he group agreed that, while a useful tool to assist the Case Manager … the observation guidelines would only confuse the physicians." Attendees included Division IV President Bill Hussey, as well as Debbie Cothern, CHS's Vice President of Quality and Resource Management, Sandy Carson, and Jackie Moran, all of whom answered to Lipp—Smith's and Cash's direct report.

90. CHS's Physician Advisory Board ("PAB"), headed by Smith and Cash, adopted the RPAC's reasoning and recommendation in unanimously deciding on January 14, 2005 to continue excluding observation guidelines from the Blue Book. The PAB's position excluding observation continued for almost five years.

91. REDACTED

92. In 2006 CHS retained Primaris to perform an independent study called the "One-Day Stay Project," and found that 61% of the randomly chosen patient files at Northeast Regional Medical Center

(MO) during the second half of 2005, who had one-day stays, failed the InterQual admission criteria for admission, and calculated the Medicare overpayment at $180,600. Upon information and belief, these findings were reported to Smith.

93. In May 2007, another consultant, Health Services Advisory Group, expressed its concerns to CHS (Payson Regional Medical Center) that the "Blue Book criteria, specifically the justification for patients admitted with DRG 143 chest pain [a Medicare billing reimbursement code], … would allow patients who should be categorized as *Observation status* to be admitted as *Inpatient status*." Upon information and belief, these findings were reported to Lipp who, in turn, advised Smith.

94. CHS's own internal audit found that patients were being inappropriately admitted using the Blue Book. On August 17, 2007, Carol Hendry (V.P. and Corporate Compliance and Privacy Officer)—who reported directly to Smith—prepared a compliance "Status Report," reporting on a number of ongoing compliance related issues, including the findings of an internal audit performed at Chestnut Hill Hospital, which found that out of 72 "one-day stays" (*i.e.*, patients who are admitted for only one day), an astounding 56 did not meet CHS's inpatient criteria.

95. Hendry's "Status Report" also indicated that she would "have a report to [Smith] by early next week" regarding the "Dr. Joe Zebrowitz issue." Dr. Joseph Zebrowitz ("Zebrowitz"), of Executive Health Resources ("EHR"), a longtime expert consultant, was hired by CHS to review its admissions practices. Zebrowitz documented for

Hendry compliance problems at numerous CHS hospitals relating to the Blue Book criteria, which resulted in short-term admissions called "one day stays"—a Medicare red flag. In his report on Watsonville Community Hospital (CA), as of November 30, 2006, Dr. Zebrowitz highlighted CHS's serious regulatory risks, observing that CMS was aggressively investigating Medicare fraud with a focus on the red flags for lack of "medical necessity." Zebrowitz reported that at Watsonville he saw "almost no medical observation—this is a significant red flag." Hendry sent Dr. Zebrowitz's assessment of CHS' compliance practices and his report on Watsonville Community Hospital directly to Smith and Cash.

96. On September 7, 2007, Hendry provided Smith with a summary of the investigation of Dr. Zebrowitz's allegations.

97. On January 21, 2008, Zebrowitz emailed Carol Hendry to reiterate his concerns regarding CHS's medical necessity compliance. Zebrowitz advised Hendry that he was retained as an expert witness and consultant in connection with the OIG's investigation and recently-concluded a $26 million settlement of claims against St. Joseph Hospital of Atlanta.

98. Zebrowitz attached the DOJ's press release, which stated that the settlement covered claims against St. Joseph's for short stay inpatient admissions, usually of one day or less, which should have been billed on an "outpatient observation basis."

99. Zebrowitz advised Hendry:

> The lesson we took away from the St. Joe example was 'Do not get the OIG to investigate you.' . . . However, I think your current "processes" and underlying basis (such as —we don't really have any observation) place your organization at serious risk." (Emphasis added).

Hendry forwarded Dr. Zebrowitz's investigative findings to Cash.

100. On January 30, 2008, Dr. Zebrowitz sent his conclusions to Carol Hendry. Dr. Zebrowitz indicated that although there is no regulatory requirement that a hospital use a particular commercially available screening criteria such as InterQual, nevertheless, the basis for determining medical necessity must, in accordance with 42 C.F.R. 411.406(e), comport with either Quality Improvement Organization Guidelines or Local Standards of Care.

101. Dr. Zebrowitz concluded that the Blue Book criteria, in contrast: (1) "lacks specificity, allowing all cases to be classified as inpatient"; (2) would likely be construed as "statistically biased"; (3) results in "overcertification of inpatient"; and (4) could be construed as "an avoidance of best practices." Dr. Zebrowitz "strongly advise[d] against" using the Blue Book in a Medicare appeal because the "last thing" CHS wanted was a federal judge reviewing the Blue Book. Cash and Smith were informed of Dr. Zebrowitz's findings.

102. EHR's investigation also revealed that CHS's refusal to use observation status presented a "clear medical necessity compliance risk." In

particular, Dr. Zebrowitz found that (a) CHS instructed case managers "to make everything inpatient" and not to use observation status, and (b) Physician Advisors reported that CHS hospitals "don't have any observation." He also found:

- Chestnut Hill Hospital: ED Director stated that "15% of our admissions are not appropriate, but I was told to make them inpatient" and that "[CHS] Corporate tells us not to use observation, except for extended post-surgical care."
- Porter Hospital: The Director of Case Management was "told not to use observation."
- Laredo Medical Center: one-third of the 24 esophagitis/gastroenteritis cases reviewed failed to support inpatient admission.
- Watsonville Community Hospital: "Almost no medical observation -- this is a significant red flag," and 55% of the 31 one-day stay cases reviewed failed to support inpatient admission.

103. Dr. Zebrowitz reported that "case managers have repeatedly expressed their discomfort at following [CHS's no-observation] instructions, creating an environment of clear medical necessity compliance risk and exposure." He concluded that "the fact that Blue Book is utilized by these hospitals as a rubber stamp and not a screening tool is a potential problem."

104. Despite being informed of Dr. Zebrowitz's determinations, Smith and Cash chose not to take any affirmative action. The Blue Book was

implemented *en masse* at former Triad hospitals. No comprehensive changes were made to provide observation status guidelines for another two and one-half years.[5] Despite knowing about long-standing potential Medicare violations, Smith and Cash made unqualified representations throughout the Class Period that CHS hospitals were in substantial compliance with government regulations.

105. As a result, CHS hospitals continued to improperly drive patient admissions using the Blue Book. For example, in August 2009, QRM Regional Director David Whittaker, sent a "red alert" report to Cash, Division I President, David Miller, and other CHS executives, relating to the "the lack of Medicare Observation Patients at Southern Va. Regional Medical Center." The report noted that the Medical Center "continued its 2008 trend of no observations into 2009." Whittaker stated "the zero volume of observations for such an extended period of time is a red flag for CMS and could trigger an audit of short-stay admission patients at the hospital."

106. Lipp's own staff confirmed that "there is a tremendous amount of differences between Blue Book and InterQual" and that "there is no way we can replicate [InterQual]." These facts are supported by numerous audits performed on CHS's patients. For example, in February 2009, a CMS audit of 40 chest pain patients admitted to Oro Valley Hospital

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[5] Observation guidelines for chest pain only were implemented in July 2009.

in Arizona revealed that 70% "did not meet InterQual Criteria for admission."

107. An audit of Dyersburg Hospital in early 2011 revealed that out of 185 cases – only one met inpatient [InterQual criteria]" and that CHS should not be "forcing them into a status that we cannot defend." Similarly, a Division III Volume Summary Report for 1Q 2011 stated that for Dyersburg and Pottstown, "RAC audits and its review of all chest pain admissions, were "threats to volume."

JURISDICTION AND VENUE

108. The claims asserted herein arise under Sections 10(b) and 20(a) of the Exchange Act, 15 U.S.C. §§ 78j(b) and 78t(a), and SEC Rule 10b-5 promulgated thereunder.

109. This Court has jurisdiction over the subject matter of this action pursuant to 28 U.S.C. §§ 1331 and 1337, and Section 27 of the Exchange Act, 15 U.S.C. § 78aa.

110. Venue is proper in this District pursuant to Section 27 of the Exchange Act, 15 U.S.C. § 78aa, and 28 U.S.C. § 1391(b).

111. In connection with the challenged conduct, Defendants, directly or indirectly, used the means and instrumentalities of interstate commerce, including, but not limited to, the U.S. mails, interstate telephone communications, and the facilities of the national securities markets.

PARTIES

A. Lead Plaintiff

112. Lead Plaintiff the New York City Employees' Retirement System ("NYCERS"), the Teachers' Retirement System of the City of New York ("NYCTRS"), the New York City Fire Department Pension Fund ("FIRE"), the New York City Police Pension Fund ("POLICE"), and the Teachers' Retirement System of the City of New York Variable Annuity Program ("NYCTRS Variable A") (collectively, the "Funds" or "Lead Plaintiff"), are part of one of the largest pension systems in the nation. As of June 30, 2015, Lead Plaintiff collectively had more than $160 billion in assets. On December 28, 2011, this Court appointed the Funds as Lead Plaintiff in this action.

113. NYCERS, established under Section 12-102 of the Administrative Code of the City of New York, provides pension benefits to all New York City employees who are not eligible to participate in separate Fire Department, Police Department, Teachers, or Board of Education pension funds.

114. NYCTRS maintains two separate retirement programs, the Qualified Pension Plan ("QPP") and the Tax-Deferred Annuity Program ("TDA"). The QPP, established pursuant to Section 13-502 of the Administrative Code of the City of New York, provides pension benefits to those with regular appointments to the pedagogical staff of the New York City Board of Education. The TDA was established pursuant to Internal Revenue Code Section 403(b), to provide a means of deferring income tax payments on voluntary tax-deferred

contributions. The variable investment fund of the TDA is known as NYCTRS Variable A.

115. FIRE, established pursuant to Section 13-301 of the Administrative Code of the City of New York, provides pension benefits for full-time uniformed employees of the New York City Fire Department.

116. POLICE, created pursuant to New York Local Law 2 of 1940, provides pension benefits for full-time uniformed employees of the New York City Police Department.

117. Each of the Funds purchased or acquired CHS common stock during the Class Period and suffered damages as a result of the federal securities law violations alleged herein. During the Class Period, the NYC Funds purchased a total of approximately 800,000 shares of CHS common stock on the open market, as set forth in their amended certifications annexed hereto.

B. Defendants

118. Defendant CHS is a Delaware corporation headquartered at 4000 Meridian Boulevard in Franklin, Tennessee. CHS's common stock is listed on the New York Stock Exchange (the "NYSE") under the ticker symbol "CYH."

119. CHS is one of the largest publicly-traded hospital companies in the United States and a leading operator of general acute care hospitals in communities across the country. Through its subsidiary, Community Health Systems Professional Services Corp., the Company by the end of 2011, leased or owned 131 affiliated hospitals in 29 states with an aggregate of approximately 19,695 licensed

beds. The Company's headquarters are located in Franklin, Tennessee, a suburb south of Nashville. In 2011, CHS reported $13.6 billion in net revenue.

120. In pursuit of its growth by acquisition strategy, from 2006 through 2011, CHS increased the number of hospitals by 70%, growing from 77 to 131 hospitals; increased the number of beds from 9,117 to 19,695 and more than tripled its net revenues from $4.3 billion to $13.6 billion. The bulk of this growth occurred through the July 2007 acquisition of the Triad hospital system for $6.8 billion.

121. From 2006 through 2011, between 26.8% and 32.0% of CHS's net operating revenue was derived from Medicare reimbursement payments, so CHS's success necessarily depended upon compliance with the Medicare regulations.

122. Defendant Wayne Smith has served as CHS's President, Chief Executive Officer ("CEO") and Director since 1997, and Chairman of the Board of Directors (the "Board"), since 2001. Defendant Smith is also President and CEO of Community Health's wholly owned subsidiary, Community Health Systems Professional Services Corporation, and an officer and/or director of certain of Community Health's hospitals, including: (i) Roswell Hospital Corporation; (ii) San Miguel Hospital Corporation; and (iii) Deming Clinic Corporation.

123. As an experienced industry professional, Smith knew that CHS was required to comply with Medicare reimbursement standards and other federal and state laws and approved, *inter alia*, public disclosures with the SEC that the Company

was in substantial compliance with these requirements. Yet, internally he drove improper admission practices at CHS hospitals for the purpose of obtaining higher Medicare revenue. He also closely monitored the results of the centralized and systemic "ZERO Medicare observation" strategy employed at CHS hospitals.

124. For fiscal year 2011, Smith's total compensation was approximately $21.6 million. This included $3.95 million in bonuses and incentives.

125. As described herein, while in possession of material, non-public information concerning changes in CHS's admissions practices that could impact its results, Defendant Smith sold 500,000 shares of his CHS stock, reaping unlawful profits of $8,443,908.

Insider Last Name	Transaction Date	Shares	Price	Option strike price	Profit
SMITH	5/20/2009	250,000	$26.07	$13.00	$3,267,500
	5/13/2010	243,093	$41.02	$20.30	$5,036,887
	5/14/2010	6,907	$40.50	$20.30	$139,521
		500,000			$8,443,908

126. Defendant Larry Cash has been CHS's Chief Financial Officer ("CFO") and Executive Vice President since 1997 and Director since 2001. In addition to CHS, Cash has been an executive and/or director of several public healthcare companies and as an experienced industry professional, Cash knew that CHS was required to comply with Medicare reimbursement standards and other federal and state laws, and approved public disclosures with the SEC that the Company was in substantial compliance with these requirements. Yet, internally he drove improper admission practices at CHS hospitals for the purpose of obtaining higher Medicare revenue. He also closely monitored the results of the centralized and systemic "ZERO

Medicare observation" strategy employed at CHS hospitals.

127. For fiscal year 2011, Cash's total compensation was approximately $8.7 million, including $1.4 million received in bonuses.

128. As described here, while in possession of material, non-public information concerning admissions practices, Defendant Cash sold 480,000 shares of his CHS stock, reaping unlawful profits of $7,432,100.

Insider Last Name	Transaction Date	Shares	Price	Option strike price	Profit
CASH	8/4/2009	240,000	$30.79	$20.30	$2,517,600
	4/26/2010	240,000	$40.34	$20.30	$4,809,600
		480,000			$7,327,200

129. Defendants Smith and Cash are collectively referred to herein as the "Individual Defendants," and together with CHS, are referred to as the "Defendants."

130. The Individual Defendants are liable as direct participants in the wrongs complained of herein. In addition, the Individual Defendants, by reason of their status as senior executive officers and/or directors, were "controlling persons" within the meaning of Section 20(a) of the Exchange Act, and had the power and influence to cause the Company to engage in the unlawful conduct complained of herein. Because of their positions of control, the Individual Defendants were able to, and did, directly or indirectly, control the conduct of CHS's business, and the contents of CHS's public disclosures to the investing public.

131. The Individual Defendants were provided with and approved the Company's reports and press

releases alleged herein to be misleading, and had the ability and opportunity to prevent their issuance or cause them to be corrected. Many statements in public company releases and conferences were specifically made by the Individual Defendants. Thus, the Individual Defendants expressly, knowingly and intentionally committed the fraudulent acts alleged herein.

ADDITIONAL SUBSTANTIVE ALLEGATIONS

A. CHS Developed a Corporate Culture Centered Around Boosting Admissions

132. Throughout the Class Period, CHS highlighted in its public filings (signed by Smith and Cash), that the key components of its business strategy were: increasing revenues and earnings at its hospital facilities and growing through acquisition of other hospital chains. CHS explained that since "60% of [its] hospital admissions originate in the Emergency Room," CHS took affirmative steps to grow its ED admissions. CHS also highlighted the importance of Medicare and Medicaid programs which accounted for 37% to 42% of the Company's net operating revenues between 2006 and 2011, a large percentage of which was generated through ED admissions. CHS's ability to drive up ER admissions rates in existing and newly acquired hospitals thus was critical to the Company's financial performance.

133. CHS senior executives were keenly focused on this central, publicly disclosed, goal. For example, Defendant Cash made a presentation to the Board on December 10, 2008 that emphasized that CHS could sustain revenue growth by "increase[ing] inpatient ER visits." In the Company's quarterly earnings

releases, they issued projections regarding "same store" admission growth and other financial metrics, as "guidance for analysts and investors." On November 8, 2008, Cash explained to his Management Committee that boosting admissions was needed "to meet analyst's earnings expectations and impact CHS's stock price favorably." Increasing the Company's market capitalization facilitated CHS's growth-by-acquisition strategy by increasing the value of CHS's stock thereby facilitating CHS's ability to issue higher levels of debt to support additional acquisitions.

134. CHS, however, then concealed from the investing public the improper practices that made the growth in its admission rates possible.

135. In order to centrally organize and manage its hospitals, CHS divided its geographically dispersed hospitals in 29 states into five operating "Divisions" listed below as well as a corporate leadership team or group:[6]

Division I:	Alabama, Florida, Georgia, Mississippi, North Carolina, South Carolina, Virginia;
Division II:	Arkansas, Louisiana, Texas;
Division III:	Pennsylvania, New Jersey, Tennessee;

[6] According to CHS's internal records, the States included within each Division have, from time to time, been reorganized. This list depicts the Divisions as they existed between 2008 and 2013. In 2013, CHS reordered the Divisions to add a sixth Division.

Division IV:	Alaska, Arizona, California, Nevada, New Mexico, Oklahoma, Oregon, Utah, Wyoming; and
Division V:	Illinois, Indiana, Kentucky, Missouri, Ohio, West Virginia.

136. As described herein, the misuse of the Blue Book criteria and admission benchmark enforcement techniques are evidenced at every division at CHS.

137. CHS states that each hospital affiliated with the CHS holding company or the professional services corporation is owned or leased and operated by a separate and distinct legal entity. CHS maintains publicly that each of these legal entities is responsible for the healthcare services delivered at its respective facility and employs its own management teams. In practice, however, at all times relevant to this action, CHS did not allow these subsidiaries any autonomy in the most important aspect of running a medical facility namely, ensuring that patients receive medically appropriate care.

138. CHS utilized a tight reporting and monitoring structure as described in ¶ 135 *supra*, whereby each hospital reported to its Division President, who in turn reported directly to Smith and Cash, and the Board.

139. Each of the five Divisions is headed by a President, and executive staff. Each Division submitted presentations directly to CHS's Board of Directors. Cash and Smith received and reviewed all Division presentations. These Presentations reported the financial results of the Division and focused on several key metrics, including EBITDA,

ER "Volume Growth," "ER Visits" and ER "Admission Rate," ER 65-over admissions rate and Length of Stay ("LOS").

140. The consolidated admission statistics of each Division and the hospitals within each Division were closely monitored by CHS, Smith and Cash. For example, on September 12, 2007, Division I reported to the Board of Directors that three of its hospitals needed to "improve" their ER admissions rates. Similarly, on May 20, 2008, Divisions I though IV submitted presentations to the Board of Directors. For example, Division I President, David Miller, reported that his entire Division's "admission rate" improved to 15.8%.

141. The Board presentation submitted by Division III's President, Gary Newsome,[7] on May 20, 2008, is typical of Division presentations in both the manner in which it reports and its focus on admissions statistics. In particular, Newsome reported that CHS's Division III successfully attained a 17.6% "overall Group admissions rate" for the First Quarter of 2008. The report also indicated that (1) the Chestnut Hill Hospital in Pennsylvania achieved 4.5% "Admissions growth"; (2) the Heartland Regional Medical Center in Marion, IL

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[7] In September 2008, Newsome, former CHS President of Division II and later Division III, left CHS to become the President and CEO of Health Management Associates, Inc. ("HMA"). HMA is currently the target of government investigations and a defendant in civil *qui tam* litigation alleging that HMA, like CHS, was overbilling Medicare by improperly admitting patients who should have been placed in observation. Newsome has since retired from HMA and is now reportedly living in Uruguay.

achieved 5.5% "Admission growth"' (3) Tennessee's "[c]ollective admission ahead of prior year" by 7.6%; (4) "Jackson - admissions up 21% over PY"; and (5) Gateway Medical Center in Clarksville, TN achieved "17% Admissions growth." Newsome also explained that Heartland's ER services "are consistently one of Division III's top performers on all Pro-MED metrics."

142. Moreover, according to the minutes of the Board meeting held on May 19, 2009, the Board of Directors reviewed an "Operations Update" PowerPoint presentation prepared by Marty Schweinhart, CHS's Senior Vice President of Operations, which reviewed the "standardized and centralized" aspects of CHS's operations. Schweinhart reported that one of the "key areas and initiatives on the *revenue side*" included "emergency room management – installation of Pro-MED with 12 months of acquisition and focus on emergency room inpatient admission rates." (Emphasis added).

B. CHS Ignored Patient Safety and Medicare Rules in Order to Boost Its Revenues

143. CHS failed to disclose that the Company had adopted a policy that violated a fundamental principle of medical care: to treat patients based upon their clinical needs, rather than boost the hospital's bottom line, and to seek reimbursement for only those services that are reasonable and medically necessary to serve the patient.

144. When a patient suffering from a medical condition seeks treatment at a hospital's ED or is otherwise referred to the hospital, physicians have three choices with respect to forms of treatment: (1)

treat the patient at the hospital on an inpatient basis; (2) admit the patient on an outpatient observation basis for care and monitoring that is generally expected to last less than 24 hours; or (3) not admit the patient, instead discharging the patient following treatment.

145. The use of observation status to treat patients is widely recognized as an essential tool for improving clinical decision making and providing cost effective medical care. The Medicare Benefit Policy manual, Ch. 4, provides an overview of the observation level of care, Paragraph 209.1, Observation Services Overview, states:

> Observation care is a well-defined set of specific, clinically appropriate services, which include ongoing short term treatment, assessment, and reassessment, that are furnished while a decision is being made regarding whether patients will require further treatment as hospital inpatients or if they are able to be discharged from the hospital. Observation services are commonly ordered for patients who present to the Emergency Department and who then require a significant period of treatment or monitoring in order to make a decision concerning their admission or discharge. Observation services are covered only when provided by the order of a physician or another individual authorized by State licensure law and hospital staff bylaws to admit patients to the hospital or to order outpatient services.

146. Outpatient observation care is typically appropriate for patients whose medical conditions require diagnostic evaluation because: (1) the

balance between the probability and severity of disease warrants further evaluation; (2) the patient presents a condition that cannot be readily diagnosed without additional testing; or (3) the physician needs more time to evaluate the patient's symptoms to determine the most appropriate medical treatment. Louis Graff, MD, *Principles of Observation Medicine*, *in Observation Medicine* (Louis Graff ed. 2010), *available at* http://www.acep.org/content.aspx?id=46142&terms=Observation%20Medicine.

147. Medicare Benefit Policy Manual, Chapter 6, Section 20.6B, provides that "when a physician orders that a patient receive observation care, the patients' status is that of an outpatient. The purpose of observation is to determine the need for further treatment or for patient admission. Thus, a patient receiving observation services may improve and be released, or be admitted as an inpatient."

148. Medicare reimbursement for inpatient services is substantially greater than reimbursement for observation services. Both inpatient and observation services are reimbursed under prospective payment systems. Medicare inpatient reimbursement is based upon Diagnosis Related Groups ("DRG's") and based upon the patient's diagnosis.

149. DRG's refer to a patient classification system adopted by Medicare in 1983 and are based upon distinct diagnosis groupings. This system provides a means for relating the type of patients a hospital treats with the associated costs of treating the patient. DRG's are based upon the patient's principal diagnosis, gender, age surgical and diagnostic procedures, discharge status and the

presence of complications or co-morbidities. Medicare utilizes this system to reimburse acute care hospitals prospectively, utilizing a predetermined rate per case, based upon the patient's principal diagnosis. Medicare's view is that patients within a given DRG category are clinically similar having common demographic, diagnostic, and therapeutic attributes and use approximately the same proportion of hospital resources and have similar acuity levels. If other co-morbidities (diagnoses) are documented or other procedures are performed, the DRG can change and the prospective payment in turn increased.

150. Medicare reimburses outpatient services, including observation services, based upon Ambulatory Payment Classifications ("APC's"). The Outpatient Prospective Payment System was introduced by Medicare in 2000 and since then, all outpatient services are assigned to one of approximately 900 categories and each APC is assigned a national payment rate that is based upon the median cost for all services within the APC.

151. Outpatient observation care is also appropriate for patients who require short-term treatment of emergency conditions. In addition, patients who require therapeutic procedures that do not necessitate inpatient admissions, but who nonetheless require some period of hospital care, are generally treated in observation.

152. One benefit of outpatient observation care is its cost effectiveness relative to inpatient treatment, because the former requires shorter hospital stays and, typically, less testing and monitoring. The decision of whether to treat a patient on an inpatient admission basis or outpatient

observation basis also has significant financial ramifications for hospitals. Hospitals receive a much larger reimbursement from Medicare for treatment of a patient on an inpatient admission basis than on an outpatient observation basis.

153. According to the Medicare Payment Advisory Commission ("MedPAC"), for some medical conditions, during the Class Period, the Medicare program reimburses hospitals nearly 1000% more (or approximately $7,000 more per patient) when the patient is admitted to the hospital as compared to treatment for the same patient in observation status. Presentation, MedPAC, "Recent Growth in Hospital Observation Care" (Sept. 30, 2010), *available at* http://www.medpac.gov/transcripts/observation%20sept%202010.pdf.

154. In order to temper the incentive hospitals may have to improperly steer patients into admission, Medicare laws and guidelines prohibit hospitals from billing Medicare for treatment of a patient admitted to the hospital unless a physician, at the time the patient presents to the hospital, determines that the severity of the patient's condition requires care that the physician expects to meet or exceed 24 hours, and that placing the patient in a less intensive setting would significantly and directly threaten the patient's safety or health. *See* Medicare Benefit Policy Manual, Ch. 1 § 10; Medicare Program Integrity Manual, Ch. 6 § 6.5.2.

155. The Medicare Program, 42 U.S.C. § 1395, *et. seq.*, ("Medicare") reimburses hospitals only for treatment that is "reasonable and necessary for the diagnosis or treatment of illness or injury." 42 U.S.C. § 1395y(a)(1)(A). In addition, Medicare

intermediaries who make Medicare payments are prohibited under federal law from using Medicare funds to pay for services if those services were not "medically necessary, reasonable, and appropriate for the diagnosis and condition of the beneficiary." Medicare Program Integrity Manual, Ch. 6 § 6.5.2. In this regard, "[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." *Id.*

156. Under Federal law and applicable Medicare guidelines, absent a medical need to treat the patient on an inpatient basis, the patient must not be admitted as an inpatient and Medicare is not responsible for payment of inpatient treatment. Additionally, Medicare participants are required to disclose all known errors and omissions in their claims for reimbursement, and failure to do so is a violation of law. 42 U.S.C. § 1320 7b(a)(3).

157. The use of outpatient observation is also appropriate when the need for inpatient admission cannot be medically determined and when additional time is needed to evaluate the patient or when the physician believes the patient will respond rapidly to treatment. Generally, Medicare coverage for outpatient observation is limited to a 24 hour period.

158. CHS contravened these Medicare provisions by creating and utilizing the Blue Book's inappropriate inpatient admissions criteria and "no observation" policy. CHS management had the Blue Book written to provide a criteria to justify the admission of patients who should instead have been observed and/or released.

159. Defendants were experienced in billing for Medicare patients and knew the prohibitions at all relevant times. Defendants knew (i) patients in hospitals are exposed to the risk of hospital-acquired conditions; and (ii) that CHS could incur significant penalties and liability arising from Medicare fraud investigations and fines.

160. CHS failed to disclose these improper admissions practices and when they were exposed in the *Tenet Litigation*, CHS conceded it had recently started to phase out the Blue Book, the use of which led to a $98 million settlement with the DOJ. Defendants falsely claimed that the switch to criteria that complied with Medicare regulations would not have a negative impact. However, by October 2011, it was clear that CHS's abandoning the Blue Book had resulted in an accelerating decline of admissions.

C. CHS's Undisclosed Practices Increased Patient Admissions Improperly

1. CHS Systemically Used the Blue Book's "Admissions Justifications" to Boost Medicare Revenues Despite a Lack of Medical Necessary

161. Under Medicare regulations, hospitals are required to maintain a set of admissions guidelines for determining whether a patient's condition is serious enough to warrant inpatient treatment. Such criteria are required to support treatment that is medically necessary. 42 C.F.R. § 482.30(c)-(d) ("The UR plan must provide for review for Medicare and Medicaid patients with respect to the medical necessity of -- (i) Admissions to the institution; (ii) The duration of stays . . . .").

162. In contravention of these Medicare rules, CHS developed corporate-wide admissions criteria under the Blue Book that systematically encouraged medically unnecessary inpatient admissions at its hospitals. In doing so, CHS management directed CHS Hospital CEOs, ED Directors and Case Managers to use a "no observation" policy, notwithstanding repeated warnings to senior management that these practices were a clear "medical necessity" compliance risk. Newly acquired Triad hospitals were instructed that by "using the Blue Book admission criteria as soon as possible … the hospital should experience a significant reduction in Medicare and other outpatient observation status and a significant increase in inpatient admission." CHS's own CMO cautioned that the "Blue Book [is] not adequate" and that the CEOs "felt it was time to revisit the whole issue." They also ignored Dr. Zebrowitz's findings that the Blue Book's lack of specificity allows "all cases to be classified as inpatient" and "precludes cases from undergoing appropriate physician review and ensuring appropriate physician documentation and valid certification."

163. The following examples, revealed in the *Tenet Litigation*, highlight the Blue Book's improper admission criteria as compared to objective clinical factors in InterQual.

a) <u>Chest Pain</u>

164. The Blue Book contained Admission Justifications that were either inappropriate or not relevant for physicians to consider in determining whether it was medically necessary to admit a chest pain patient to the hospital or treat in observation.

165. Under standard clinical practice, when a patient presents to the hospital with chest pains, there are varying levels of care that may be provided to the patient, depending on the severity of the patient's condition. Given that chest pain is a very non-specific complaint, meaning that there are many causes of chest pain other than a heart attack, patients often are initially evaluated in observation in order to determine whether or not they are in fact having a heart attack or suffering from a lack of oxygen to the heart. Many chest pain patients are appropriately treated in observation, where standard tests may be run to determine whether the patient has had a heart attack, in which case the patient likely would be admitted to the hospital, and if not, the patient would likely be discharged. Once a decision is made to admit a patient to the hospital, there are varying levels of care in the hospital depending on the severity of the patient's clinical condition. The initial level of care for stable patients requiring admission is the inpatient general medicine or surgical floor setting. Those requiring a higher level of care may be placed in telemetry or intermediate care setting. Those patients that are most critically ill may be placed in the critical care unit.

166. Prior to August 13, 2009, the Blue Book did not include any criteria for placing ED patients in observation. On the contrary, in her presentation, "Observation Status and One-Day Stays, What You Need To Know," Lipp, Smith's direct report, directed hospital case managers that "no chest patients in observation"; rather, all such patients were to be admitted.

167. The revised 2009 Blue Book set forth observation status for a single condition—chest pain. The three levels of care, include two levels of admissions for chest pain patients, and one for observation, each with separate "Admissions Justifications": 1) "Very Low Risk: Observation or Discharge;" 2) "lower risk/telemetry (Green/Blue cases)"; and 3) "high and moderate risk levels/CCU (Orange/Red cases)." For each of these categories of care, the Blue Book contained admissions criteria that are both inappropriate and inconsistent with standard clinical decision-making.

168. With respect to chest pain observation, when a patient presented to the hospital with chest pain - one of the most common presenting emergency room complaints - it is accepted clinical practice to run two to three sets of blood tests on the patient every six to eight hours to measure the levels of cardiac enzymes (specifically, a cardiac marker known as troponin) in the blood. An elevated troponin level from one test to the next indicates that the patient's cardiac wall likely has suffered a loss of blood flow, meaning that the patient is at risk of suffering or having suffered a heart attack. If, as is often the case, the patient's troponin level does not increase from one blood test to the next, the physician may rule out a heart attack and send the patient home. In addition, it is standard practice to perform two electrocardiograms ("ECGs"), which measure changes in heart rhythm that may be indicative of a heart attack during the same time period that the cardiac enzymes are measured.

169. Because these cardiac enzyme tests and ECGs may be completed in less than 24 hours, it is

standard practice for these patients to be treated in observation, rather than admitted to the hospital. Indeed, treating chest pain patients in observation is so common that some hospitals have observation units dedicated solely to evaluating patients complaining of chest pain.

170. However, the Blue Book justified placement of a patient in observation only *after* the patient has two negative serial ECGs and two negative sets of cardiac enzyme tests (meaning they are not in cardiac arrest). In other words, under the Blue Book, these evaluation tests were not to be performed until after patients are already admitted to the hospital.

171. With respect to Chest Pain Telemetry Admissions, the Blue Book Admission Justification criteria for chest pain, lower risk/telemetry were at odds with standard criteria. For example, at CHS hospitals a patient with chest pain was to be admitted to the telemetry unit rather than placed in observation if he or she merely had a general risk factor for cardiac disease (*e.g.*, hypertension, diabetes, or hyperlipidemia) coupled with only one of the following:

(a) New chest pain in the presence of a significant history of coronary artery disease;

(b) A recent visit to the hospital with complaints of chest pain;

(c) Chest pain that may be reproduced by pressing on the chest; or

(d) "Atypical symptoms," such as shortness of breath, fatigue, sleeplessness, and/or anxiety.

172. These Admission Justification criteria were weighted toward admissions and inconsistent with accepted clinical standards for inpatient admissions, because many patients who present with chest pain have a history of a common cardiac risk factor that is not necessarily indicative of a medical need for inpatient care, such as hypertension (a very common diagnosis in the U.S. population). Furthermore, the criteria identified in (a) through (d) above are very different from the accepted clinical standards for hospital admission, such as having positive cardiac enzymes. For example, the Blue Book treats a "recent visit to the hospital with chest pain" as a criterion for admission. While it is certainly a part of a patient's history, it is not any indication of a patient's clinical severity of illness. Upon information and belief, none of these criteria are representative of standard clinical criteria that physicians consider when deciding whether to admit a patient with chest pain to the hospital. Moreover, under InterQual, these Blue Book criteria would not support the admission of a patient to the hospital.

173. With respect to Chest Pain Cardiac Care Unit ("CCU") Admissions, the CCU is reserved for patients with the most critical medical conditions who require intensive and rapid treatment for survival. The Blue Book Admissions Justification criteria for CCU admission, however, included, many diagnoses that had no bearing on the severity of the patient's existing illness, but rather, addressed only the patient's medical history or conditions that are

common among many chest pain patients - conditions, under standard clinical practice, with no impact on whether a patient should be placed into the CCU. For example, the Blue Book Admission Justification criteria for admission to the CCU include several criteria, two or more of which must be met to justify an admission to the CCU. Several of these criteria, upon information and belief, are out of line with standard clinical decision-making, including the following:

(a) A history of smoking, hypertension, hyperlipidemia, or diabetes;

(b) Two or more episodes of pain;

(c) Oxygen saturation less than 90;

(d) Rest angina less than 20 minutes (resolved with rest or nitrates); and

(e) Indeterminate CKMB or Troponin.

174. Upon information and belief, each of these criteria is not relevant to the determination of whether care in the CCU is medically necessary. For example, whether a patient is a smoker or has hypertension, for example, has no bearing on the severity of the patient's condition and does not inform the need for CCU admission. Further, upon information and belief, chest pain patients frequently present with two or more episodes of pain, meaning that this criterion is not indicative of the severity of a patient's chest pain necessary to require the highest level of care. In addition, having a patient with an oxygen saturation level of less than 90 is extremely common, not in and of itself life threatening, and easily treatable with supplemental oxygen. When angina is resolved with rest or nitrate

therapy, there is no medical necessity of treating such patients in an intensive care setting, which is reserved for the most critically ill patients. Indeterminate test results for a patient's troponin levels are not, under standard clinical practice, a justification for admitting the patient into the CCU, but rather, just an indication that further testing should be performed.

175. In sum, in many cases where the Blue Book criteria inappropriately dictated admission for a chest pain patient, Medicare and industry-accepted clinical practice would place the patient in observation status. In the case where patients present with chest pain, the standard of care through an electrocardiogram and cardiac enzyme blood testing may be used to determine whether or not a patient may be having a heart attack. If so, then patients may then be admitted to the appropriate inpatient setting and appropriate level of care intensity. Patients that are ruled out for an acute heart attack, as the vast majority of "chest pain" patients are, may be discharged home. CHS's Blue Book, however, barred that standard medical practice.

b) <u>Syncope or Pre-Syncope</u>

176. In addition to Chest Pain, the Blue Book's Admissions Justifications included many criteria that are inappropriate for determining whether a patient with pre-syncope or syncope (dizziness or fainting) should be admitted to the hospital or should instead be treated in observation.

177. Under standard clinical practice, when a patient presents to the hospital complaining of

dizziness (pre-syncope) or fainting (syncope), the physician performs several tests to eliminate any critical causes that may be responsible for these episodes, such as the potential for a heart attack, a stroke in the brain, or some form of structural heart disease or acute heart arrhythmia. These tests are standard in most hospital settings and can be performed within a 24-hour period. Such patients typically are placed in observation so that these critical, though rare, causes of syncope may be ruled out. Once in observation, syncope or pre-syncope is often found to be due to dehydration (as determined by measuring a patient's drop in blood pressure between lying down and standing up) or a vasovagal reaction (a very common cause of fainting in adults). Both of these etiologies are much less critical and can be treated simply in observation. Patients with dehydration will be rehydrated during their observation stay through intravenous ("IV") fluids, and, as long as the syncope does not recur, will be sent home. Patients with vasovagal episodes will follow up with their primary care physician as an outpatient, with further treatment if the episodes recur. Regardless, these patients typically are treated in observation.

178. Rather than treat these patients on an outpatient basis, the Blue Book Admission Justification criteria called for the admission of patients over 60 with fainting episode. Upon information and belief, age is irrelevant in the case of syncope. Regardless of the etiology, age is not a risk factor for syncope, and all patients, regardless of age, will undergo the same workup and battery of testing discussed in the previous paragraph, which are appropriately conducted in observation.

Additionally, the Blue Book admissions criteria included patients who have a "Postural BP greater than 15 mm," indicating that patients found to have a positive "orthostatic testing" (such as a drop in BP of greater than 15mm Hg between a standing and sitting position) was admitted. However, such a blood pressure drop may be due to dehydration, which is something easily treated in an observation status with IV fluids and rehydration. Once again, this Blue Book criterion was out of line with the clinically accepted standard of care.

179. In comparing InterQual to the Blue Book, InterQual states that the criteria for observation are, as described above, pre-syncope or syncope of unknown etiology. Upon information and belief, this is appropriate and consistent with accepted standards of clinical care. Further, once a patient is found to have a more critical cause of syncope, such as structural heart disease or an arrhythmia, InterQual indicates that it is reasonable to admit such patients to the hospital, but the majority of patients are simply dehydrated, appropriately treated with IV fluids in observation, and discharged home.

c) <u>Community Acquired Pneumonia</u>

180. Another example of where the Blue Book justified patient admission, but the standard accepted practice does not, involves Community Acquired Pneumonia ("CAP"). On information and belief, the Blue Book's Admission Justifications criteria ignored accepted clinical practices for determining whether a patient presenting with CAP is ill enough to require inpatient treatment, or

whether the patient could, instead, appropriately be treated in observation.

181. Admission of a patient with CAP is justified under the Blue Book if the patient presents with a cough and rales (the presence of fluid in the lungs). However, on information and belief, many patients who have pneumonia - regardless of severity – show a cough and rales on exam. Thus, the mere existence of these findings tells the physician nothing about whether a patient presenting with a cough and rales has a clinical picture that correlates with severity of illness requiring admission to the hospital.

182. Similarly, an admission of a patient with CAP is justified under the Blue Book if the patient presents with a cough and infiltrate or atelectasis. On information and belief, the mere existence of a cough and abnormal chest X-ray is only relevant to informing the physician that the patient may have CAP; standing alone, the presence of these findings provides information on a possible diagnosis, but does not justify hospital admission. Clinical presentation, a critical component of the decision-making process regarding admission or observation, is not taken into account in the Blue Book.

183. Under InterQual, patients presenting with a cough and rales or an abnormal chest X-ray would not, absent other symptoms, be admitted to the hospital for treatment. Instead, such patients would be examined to determine whether they have an elevated breathing rate, a fever, or a high white blood cell count, and most importantly, whether the patient is 65 or older. In the absence of serious additional criteria (for example, a breathing rate above 29), the patient would be treated in

observation with IV antibiotics and monitored for up to 24 hours for improvement. In the typical case where the patient responded favorably to such treatment, the patient would be sent home, and if the condition worsened, the patient would be admitted to the hospital.

184. Finally, the Blue Book permitted the admission of a CAP patient with a cough and a temperature of 102 degrees and a white blood cell count of 15,000 or greater. On information and belief, it is well accepted, however, that a patient's temperature and white blood cell count do not strongly correlate with the severity of disease without consideration of age and presence of co-morbidities. Thus, absent other factors (such as advanced age or an immune system disease), there was no absolute clinical basis for inpatient admission.

d) Cellulitis

185. On information and belief, the Blue Book's Admission Justification criteria also were deficient when applied to patients presenting with signs of cellulitis, an infection of the skin that can cause pain, fever, and elevated white-blood-cell counts. For example, a patient presenting with a possible cellulitis and either an elevated white blood cell count and a temperature over 102 degrees, or a "weeping wound," may be admitted to the hospital. On information and belief, these admission criteria fall outside accepted clinical practice as they individually do not provide evidence as to the severity of a patient's cellulitis. A patient presenting with only these conditions would not, under InterQual, be admitted to the hospital. On

information and belief, such patients would either be effectively treated with IV antibiotics in observation for 24 hours and discharged when their condition improved, as cellulitis often does with 24 hours of antibiotic treatment, or would be given one dose of IV antibiotics in the emergency room and sent home with antibiotics by mouth and a follow up appointment soon after the ER visit.

186. The Blue Book Admission Justification criteria ignored the important inquiry regarding complexity and severity of cellulitis, a question that doctors often face when determining whether a patient may be treated in observation or admitted to the hospital for treatment, and the length of time that would be required to treat a cellulitis patient with IV antibiotics. On information and belief, this determination is driven by the part of the body that is affected (cellulitis of the face, hand, or foot is more difficult to treat than the upper arm, thigh, or calf); co-existing medical conditions of the patient (patients with diabetes face greater risk associated with cellulitis, often supporting inpatient treatment); and signs of sepsis or shock (patients with low blood pressure, acute confusion, or bacteria in the blood are at the highest risk for complications). These widely accepted clinical factors are primary considerations under the InterQual admissions criteria, but under the Blue Book, less clinically relevant factors were considered to justify inpatient admissions.

187. In sum, CHS ignored Medicare rules to create a liberal and over-simplified set of ER admissions criteria and enforced admissions practices.

D. CHS's Admission Rates Diverge Dramatically From Its Competitors

188. The success of CHS's inappropriate practices becomes readily apparent when CHS's observation and admission rates are compared to the hospital industry and to its competitors.

189. Tenet initially retained two "leading" healthcare consulting firms, to study how CHS's observation and admission rates compared to other well-known hospital systems. Avalere Health LLC ("Avalere") analyzed available data from CMS while Tenet's other consultant analyzed data from the American Hospital Directory. Both consultants reached substantially similar conclusions. Lead Plaintiff's industry specialist independently confirmed the conclusion of Tenet's experts.

190. Specifically, statistical analyses performed by Tenet's consulting firms revealed that in 2009, nearly 95% of CHS's hospitals had outpatient observation rates below the national average, with nearly 70% of CHS's hospitals more than 50% below the national average.

191. Conversely, CHS's percentage of one-day stays in 2009 was a statistically significant 22.5% higher than the national average.

E. Lead Plaintiff's Statistical Evidence Confirms That CHS's Strategies Worked

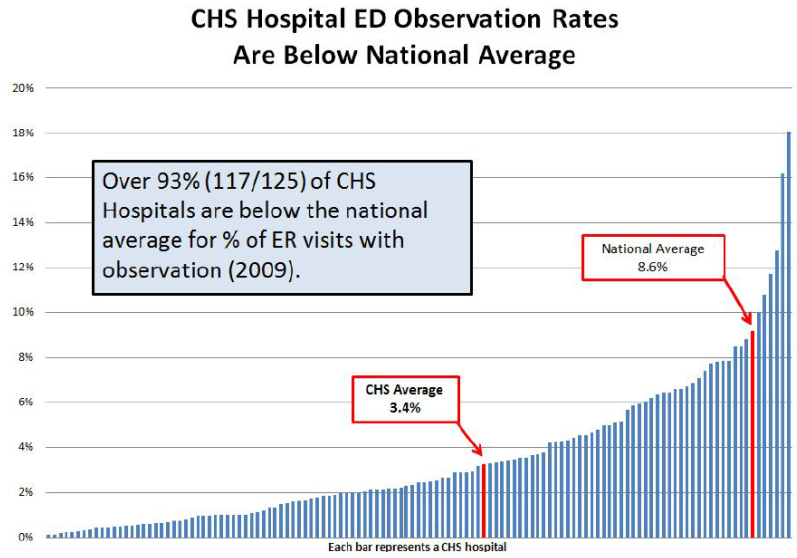
192. CHS's undisclosed practices were highly successful in boosting its ED admission rates. As part of its investigation, Lead Plaintiff retained a world-renowned expert in health economics and finance to perform numerous statistical analyses of CHS's Medicare data. This healthcare consultant has

worked for 25 years as a consultant for RAND, the largest funded health research service in the world. CHS hospitals were a consistent outlier with higher admits and lower observations than peer hospitals.

193. Lead Plaintiff's healthcare consultant found that over 93% of CHS's hospitals had observation rates below the national average. This means that a patient was far more likely to be treated in the higher-paying inpatient admission status, and far less likely to be treated in lower-paying observation status, if the patient visited a CHS hospital than if the patient visited a hospital operated by CHS's peers. Further, nearly 70% of CHS hospitals admitted ER patients for one-day stays at a rate substantially above the national average. The findings of Lead Plaintiff's healthcare consultant are consistent with those of Avalere's as follows:

1. CHS's Observation Rate vs. Industry

194. Lead Plaintiff's healthcare industry specialist's analysis determined that CHS's Medicare observation rate in 2009 was 60% below the national average.



195. The analyses performed by Lead Plaintiff's healthcare industry specialist demonstrate system-wide differences in performance between CHS and its industry peers that cannot be attributed to a few outlier hospitals that skew the averages. Rather, the findings show that 93%, or 117 out of 125 CHS hospitals, were below the national average for the percentage of ER visits with observation.

2. CHS's Observation Rate vs. Average of High Quality Systems

196. Lead Plaintiff's healthcare industry specialist's analysis also shows that CHS's 2009 Medicare average observation rate is 55% to 83% below the averages of High Quality Systems:[8]

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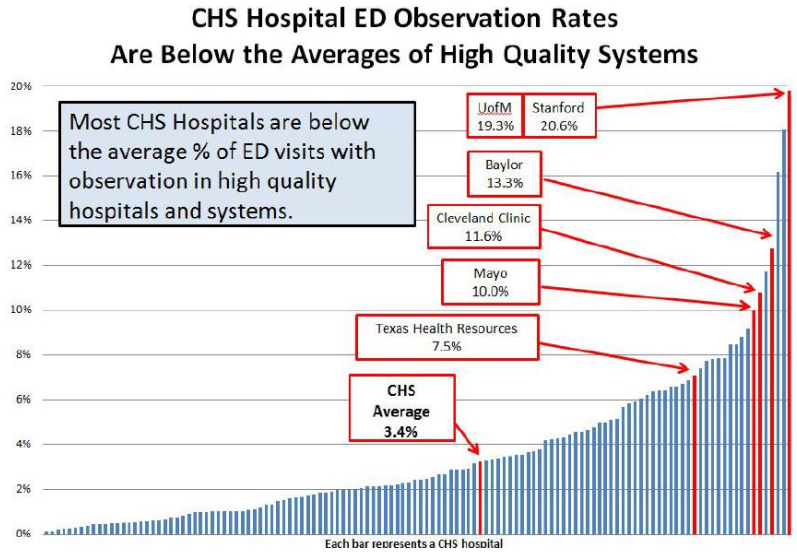
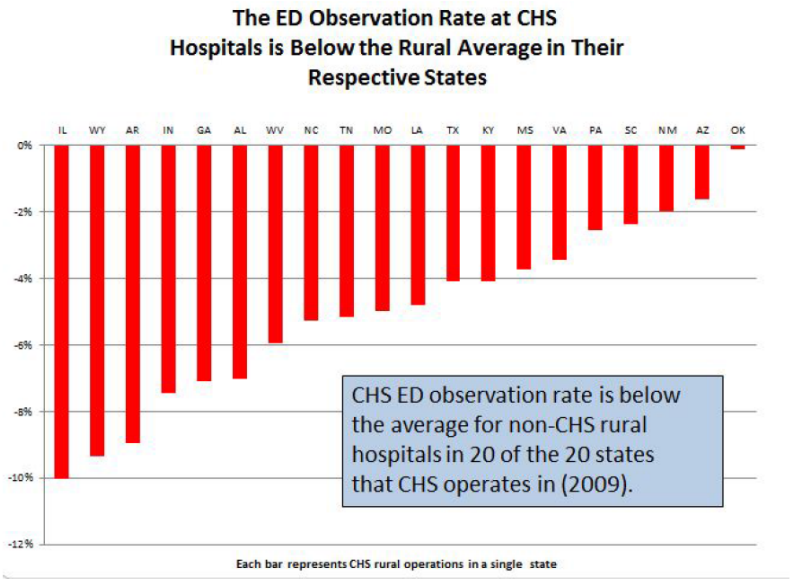
[8] High Quality Systems included the following: the Cleveland Clinic, Stanford, Texas Health Resources, the Mayo Clinic, Baylor, and the University of Michigan.



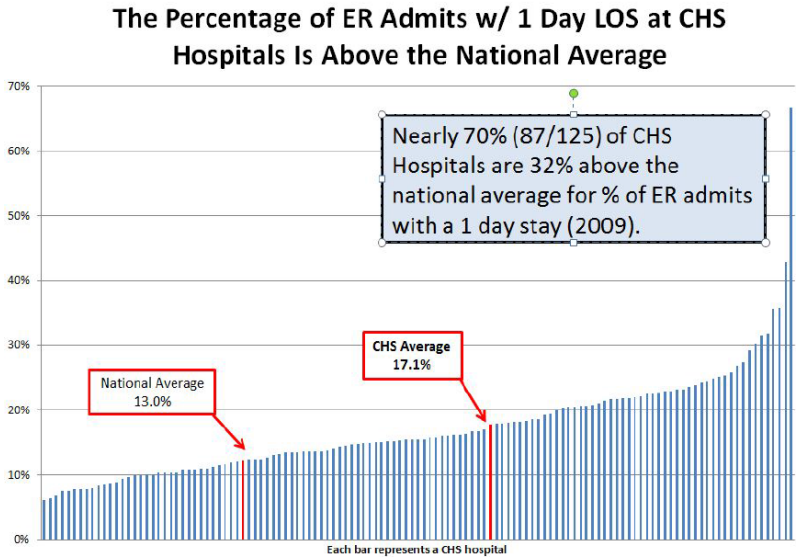
3. CHS's Observation Rate vs. Rural Hospitals in Same Geographic Area

197. Lead Plaintiff's healthcare industry specialist's analysis found Medicare observation rate in 2009 at CHS hospitals was far below other rural hospitals in 20 out of 20 states in which they operated:



4. Disproportionate Share of CHS's Admissions are "One-Day Stays"

198. Lead Plaintiff's healthcare industry specialist analyzed CHS's admission of patients with "one-day stays" – as compared to the national average. Hospitals with a high rate of "one-day stays" are considered a Medicare "red flag" as to patients who may not have required treatment on an inpatient admitted status. His analysis found that nearly 70% of CHS hospitals admitted ER patients for one-day stays at an average rate of 32% higher than the national average:



199. The testing performed by Lead Plaintiff's healthcare industry expert also establishes substantial differences in admissions and observation rates at CHS and comparison groups of hospitals over an extended time period. For example, Lead Plaintiff's expert's analysis of data for the three year period from 2008-2010 revealed that CHS hospitals have an average rate for ER visits with observation that is 58% lower than the average observation rate for large systems and 77% below the average observation rate for quality hospital systems for this time period. Conversely, CHS hospitals' average ER admission rate during this three year period was also 25% higher than the average admission rates for quality systems and 22% higher than larger systems.

200. These statistical analyses and evaluation of CHS's internal admission practices leads to the inescapable conclusion that patients whose medical needs likely required treatment in outpatient

observation status were systematically admitted for higher-paying inpatient care at CHS hospitals.

201. Defendants knew their practices were increasingly likely to invite scrutiny. By 2007, the DOJ had announced at least four multimillion-dollar settlements with hospitals for improperly billing outpatient observation admissions as inpatient admissions, including a $26 million settlement with St. Joseph, that Dr. Zebrowitz brought to CHS's attention, resulting from claims of lack of medical necessity for short stay admissions. This enhanced scrutiny of improper hospital billing was driven by CMS, which had expanded its use of Recovery Audit Contractors or "RACs," auditors paid contingency fees to identify improper Medicare billings.

F. CHS's Improper Admissions Practices Significantly Inflated Its Revenues

202. Tenet's expert estimated that as a direct result of CHS's improper practices, CHS received up to $306 million from improperly billing Medicare during 2006-2009, and up to $345 million during 2003-2009.

203. CHS's windfall from Medicare payments likely represents only one component of the total windfall CHS received through billing for unnecessary services. In 2010, CHS received as much as 27.2% of its total revenue from Medicare. But, CHS's improper admission guidelines also resulted in the billing of private payers and state Medicare and Medicaid programs for unnecessary inpatient admissions.

G. Additional Facts Support a Strong Inference of Scienter

204. With knowledge and complicity, Smith and Cash made virtually all of the alleged misstatements in CHS's SEC filings and the Company's earning calls, as well as at investor presentations and healthcare conferences.

205. Since patient admissions, particularly in the ER, were a primary driver of the Company's revenues, senior management was intimately involved in crafting and monitoring these Company-wide practices which were critical to CHS's successful business model. CHS emphasized in its Form 10-Ks and other public statements that because 55% to 60% of hospital admissions originated in the ER, "we systematically take steps to increase patient flow in our ER as a means of optimizing utilization rates for our hospitals." What was undisclosed was that these steps included practices that would not bear scrutiny including (1) use of the Blue Book's unique and warped non-industry Admissions Justifications criteria; (2) programming the Pro-MED system used in all ERs to justify patient admissions; and (3) the use of hospital incentive programs, quotas, and terminations of "low admitter" physicians, to achieve higher admissions levels.

206. Smith and Cash directed, approved, and/or participated with their seasoned management team in the standardization and centralization of CHS's operations, which they publicly acknowledged "encompass nearly every aspect of our business" and were a "key element in improving our operating results."

1. Defendants Drove Up Admissions to Satisfy Analysts and Increase CHS's Stock Price

207. Smith and Cash personally focused on admissions as the driver of the Company's stock value. In the Company's quarterly earnings releases, they issued projections regarding admission growth and other financial metrics, as "guidance for analysts and investors." Cash made clear to the Management Committee that CHS hospitals must increase "admissions to meet analyst earnings expectations and impact stock price favorably."

208. For example, Morgan Stanley (November 8, 2006) highlighted that CHS's standout performances compared to the rest of industry should soon be reflected in its stock price: "[W]e believe that CYH shares should be among the first to appreciate when industry fundamentals turn given its superior portfolio management and expense control coupled with relatively stronger admissions and pricing growth" (Emphasis added).

209. In his "Message to CEOs dated November 24, 2008, Marty Smith, Division III Group VP, reported that as a result of "18 of our 22 hospitals having an ER admissions rate that is either higher than 20% or better than prior year," CHS had achieved very good 3Q 2008 results, and was impacted far less by the stock market downturn far better than hundreds of other companies that had posted negative results. Marty Smith praised the Division CEOs: "For a Division that has long prided itself as a lead in ER performance, in the last three months you have significantly moved the needle even higher."

210. Increasing the Company's market capitalization facilitated CHS's growth-by-acquisition strategy by increasing the value of CHS's stock and facilitating CHS's ability to issue higher levels of debt to support additional acquisitions. Moreover, boosting the stock price enabled Smith and Cash to personally profit from the exercise of vested options during the Class Period. These facts support a strong inference that Defendants were motivated to mislead investors about its admission practices in order to meet or exceed investors' earnings expectations and therefore cause its stock to trade at prices higher than otherwise would have been the case.

2. CHS's Top-Down Reporting and Monitoring Structure Supports a Strong Inference of Scienter

211. Smith and Cash were key participants with outsized influence on the boards and committees that created and implemented CHS's operating strategies. For example, Smith and Cash were members of (i) the PAB which oversaw revisions to the Blue Book, including the decision not to add observation guidelines for much of the Class Period, (ii) the Corporate Compliance Workgroup that oversaw changes to CHS's observation policy, (iii) the Management Revenue Committee, which implemented and monitored admission practices at CHS hospitals, and (iv) the Board of Directors, which regularly received detailed admission metrics from the Presidents of CHS's Five Divisions.

212. Smith also (a) received direct reports from Carol Hendry (VP, Legal, in charge of investigating Medicare compliance violations), and (b) directly

supervised (with Cash) Carolyn Lipp (Sr. VP, Quality & Resource Management) relating to the development, implementation and training of the Blue Book, including CHS's decision to enforce a "no observation" policy.

213. CHS's five Division Presidents reported directly to Smith and Cash and provided them with consolidated reports on hospital admissions from their respective Divisions, and forwarded weekly ED action plans, site reviews, and admissions statistics received from hospital CEOs and administrators.

214. Smith and Cash paid bonuses to hospital executives, administrators, and ED staff to meet admission rate benchmarks. Conversely, they were advised when physicians or a physician group were terminated for being "low admitters."

3. Judge Nixon's Rulings Find a Strong Inference of Knowledge

215. This Court has credited the allegations in the *Derivative Action* showing that CHS's scheme to boost inpatient admissions, especially with respect to CHS's newly acquired hospitals, could not have been achieved without using improper means.[9] The Court observed that one year after CHS's acquisition of the Triad hospital chain, observation status rates at Triad hospitals dropped by 52%, while "one-day admissions"—a red flag for improper admissions and potential overbilling—increased by almost 33%. Order at 7. While CHS management attributed its financial success to the realization of synergies at

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[9] *See*, Order dated September 27, 2013 (Derivative Action Dkt. No. 70) ("Order").

Triad and standardization efficiencies that was a half-truth because it failed to disclose that CHS's success was in fact due to improper admissions practices. The Court concluded that the derivative complaint supported the inference that "obtaining significant increases in admissions rates… at Triad hospitals could not have been done without using improper means." *Id.* at 18. The Court further explained in denying defendants' motion for reconsideration that "Defendants' wealth of knowledge and experience with the business and management of healthcare entities, combined with their diligence and concern with increasing admission rates at CHSI hospitals, allows the Court to reasonably infer that Defendants were aware that obtaining significant increases in admissions rates – including 50% increase in admissions at Triad hospitals—could not have been done without using improper means."

4. Smith's and Cash's Participation and/or Knowledge

216. Numerous documents confirm Smith's and Cash's direction and/or knowledge of CHS's improper admissions practices that increased ED revenues. Smith and Cash supervised (with Lipp) the implementation and training on the Blue Book through corporate-imposed ED Action Plans at existing facilities and newly-acquired Triad hospitals, in order to increase ED admission rates. Indeed, Lipp was called Smith's "trusted eyes and ears." To make sure Triad hospitals understood how important this issue was to Smith and Cash, Smith and Lipp made the "rounds of all of the [CHS] division meetings and discussed the issue [of

converting observations into admissions] because it is a high priority."

217. The goal was clear – use CHS's aggressive non-industry Blue Book criteria to admit patients who would be observed under InterQual's industry-approved criteria. In other words, the same Medicare condition (*e.g.*, chest pain) that would prompt observation status in other hospitals generated increased admissions with higher reimbursement for CHS. In her standardized training sessions at former Triad hospitals, Lipp and her staff urged the ED staff to "start using CHS's Blue Book's admission criteria as soon as possible:"

> An exercise during our discussions using existing medical records of both inpatient and observation patients evidenced that <u>most of the observation patients in the exercise who had been admitted as outpatient observation status patients under the InterQual criteria would have been admitted as inpatients if the Blue Book criteria had been used. By switching to CHS [Blue Book] criteria, the hospital should experience a significant reduction in Medicare and other outpatient observation status patients and a significant increase in inpatient admissions</u> (emphasis added).

218. Smith and Cash wanted the Triad hospitals to be indoctrinated with the Blue Book. In late October 2007, Portacci (Division II President), forwarded DeTar Hospital's (Victoria, TX), "ED Action Plan" to Smith and Cash. In the Action Plan, DeTar's CEO enthusiastically observed how DeTar "represents a significant opportunity to increase

admissions based on patient meeting Blue Book admissions criteria."

219. Similarly, Greenbrier's 2008 Strategic Plan projected that by switching to the Blue Book, admissions would increase from 12% to 16%, and contribute 14% of the expected 2008 EBITDA increase.

220. Smith was instrumental in assuring that all of the Triad hospitals install Pro-MED in order to increase their admission rates. At his direction, corporate tracked hospitals' levels of Pro-MED corporate "standardization" and "how compliant [] ED docs are with the Pro-MED system recommendations for admissions."

221. The protocol used at Triad was developed with Smith's and Cash's participation. In early July 2006, Lipp sent them correspondence relating to the "ED Quality Project Action Plan," which was an effort to implement CHS admissions practices on a systematic, corporate-wide basis. The centerpiece of the project was the Blue Book, Pro-MED, along with physician and case manager training on the Blue Book. For example, Vista Health alerted both Smith and Cash in its December 2008 Monthly Operations Review that it was "reviewing daily observations that can convert to admissions," discussing them at daily flash meetings, and evaluating physicians on duty in the ER and their 21% admit rate in accordance with the CHS Blue Book.

222. Smith and Cash also approved handsome incentive bonuses to hospital CEOs and ED staff for meeting the benchmark admissions percentages. For example, in an e-mail from Division IV President Bill

Hussey to multiple hospital CEOs, Hussey told them that "Wayne Smith and Larry Cash approved a 4Q 2007 CEO admission incentive" after "discuss[ing] significant ED admission opportunities." The "4th Quarter Performance Plan" provided CEO bonuses of "10% of his 4th quarter salary" for meeting "non-self-pay admission goals."

223. Further, Smith and Cash were apprised when physicians or physician groups were branded as "low admitters" and/or terminated for failing to meet CHS's admission rate benchmark. A December 11, 2009 memorandum, concerning a site visit to former Triad South Texas Regional Medical Center (TX) explicitly states: "Emergency Department Contract....They will be terminating their agreement with Atascosa County Emergency Physicians....*The percent of admissions thru the Emergency Department continues to be below benchmark and prior year. . . Therefore, the contract will be terminated and a new group brought in.*" (Emphasis added). This memorandum was forwarded to defendants Smith and Cash with the handwritten notation, "New CEO is doing good job." Similarly, when admissions rates at each Division I hospital declined in 2Q 2010, at Smith's request, Division President Miller prepared an "analysis of the drop by physician and by medical discipline." Vista Health also alerted both Smith and Cash in this December 2008 Monthly Operations Review that the CEO was working with the medical director to "address issues with non productive physicians."

224. CHS's initiatives at Triad hospitals were successful and Smith and Cash took the credit. By 2009, Triad's observation rate declined by 52% while

the one-day stay admissions rate—a red flag for improper admission and potential over billing – increased by almost one third. Defendant Cash, speaking at a Robert W. Baird & Co. Health Care Conference on September 9, 2009, stated: "When we came to the company about 12 years ago, the admission rate out of ER was 10, 11%. Now it's 15%. Actually, the Triad hospitals had an admit rate which was lower than the CHS, and we've improved that admit rate so far."

225. While publicly touting the standardized and centralized operating strategy as the key to CHS's success as an operator and acquirer, Smith and Cash omitted to advise investors about Defendants' indefensible and centrally imposed admissions practices.

5. Smith and Cash Ignored Potential Medicare Violations

226. Because Medicare services were one of the Company's chief sources of income, knowledge of Medicare's regulations and their impacts was intrinsic to CHS's business model. Defendants acknowledged in CHS's SEC filings that government regulation was extensive and that CHS's Medicare compliance was key to success.

227. However, Smith and Cash repeatedly refused to permit observation in CHS's admission criteria even in the face of multiple warnings from staff and consultants about Medicare non-compliance at numerous hospitals. Listed below are a few examples gleaned from the DOJ production:

(a) Reports from the Mid-Atlantic and Southeastern regions that "the tracking of

and response to reported observations made it clear to the [case management directors] that there was an expectation to have no medical observation";

(b) REDACTED

(c) Report concerning Northeast Regional Medical Center (MD) that 61% of randomly chosen patient files who had one-day stays failed the InterQual criteria for admission;

(d) Report concerning Payson Regional Medical Center (AZ) that the Blue Book Admission Justifications for chest pain "would allow patients who should be categorized as Observation Status to be admitted as Inpatient Status";

(e) Report from Hendry that 68% of one-day stays sampled at Chestnut Hill (PA) did not meet inpatient criteria;

(f) "Red alert" report concerning the "trend of no observation into 2009" at Southern Virginia Regional Medical Center, which was a "red flag for CMS and could trigger an audit of short-stay admission patients at the hospital";

(g) REDACTED and

(h) Lipp's directive discussed throughout CHS corporate that "[w]e want to avoid observation as much as possible on Medicare patients and on private insurance unless the reimbursement is close to inpatient rates," which QRM acknowledged was the "exception rather than the rule," and her

training directive for "no chest pain in observation."

228. CHS's Quality Review Management prepared certain observation guidelines for inclusion in a revision of the Blue Book, but that revision was rejected in January 2005 by the Regional Physician Advisory Committee because "including observation guidelines in the Blue Book may prompt physicians to use the observation category instead of admitting the patient to inpatient status when possible."

229. On January 14, 2005, the PAB, headed by Smith and Cash, unanimously adopted the Regional PAB's reasoning and decided to continue improperly excluding observation guidelines from the Blue Book. The impact of this decision, and the manner in which CHS trained its hospital staff, to avoid putting patients in observation greatly increased the number of ED inpatient admissions which should instead have been given observation status.

230. Defendants were also aware of the DOJ's multi-million dollar settlements with hospital proprietors for improper inpatient admissions. This included the $26 million settlement with St. Joseph's Hospital of Atlanta in December 2007, involving use of short-stay inpatient admission which prompted Dr. Zebrowitz's warning to Hendry (shared with Smith) about CHS: "I think your current process and underlying basis (such as – we don't really have any observation) place your organization at serious risk."

231. Smith was also advised of Dr. Zebrowitz's critique of the Blue Book that its lack of specificity allowed "all cases to be classified as inpatient."

232. Notwithstanding the extensive evidence suggesting long-standing Medicare violations, CHS continued to prevent any observation criteria from being included in the Blue Book. Instead, Smith and Cash disingenuously sent around a one-page, one-time memo that briefly mentioned observation as a possible option, while leaving completely unchanged the elements of the Blue Book, Pro-MED and incentives which made any actual use of observation status extremely unlikely.

233. Specifically, on February 14, 2008, Smith and Cash, as members of the Company Compliance Work Group, authorized Lipp to circulate a memorandum to "clarify" observation policy. In her February 19, 2008, one-page memorandum, titled "Clarification of Observation Status," Lipp blamed the widespread lack of observation status on "possible confusion concerning our policy regarding placing patients in observation."

234. Lipp stated that "our policy is, and always has been" that a patient who "meets medical necessity criteria for inpatient admission" should be admitted to inpatient status. "If further evaluation is needed to determine whether the patient should be admitted or discharged, then the patient should be admitted to outpatient observation status."

235. Although the memorandum purported to "clarify" existing policy, the irony of course was that observation status was intentionally excluded as a treatment option in the Blue Book for several more years. The actual practice at CHS hospitals, as repeatedly documented by Dr. Zebrowitz and others, and promoted internally by Lipp (*e.g.*, "We want to avoid observation as much as possible on Medicare

patients"), was to pursue a "no observation" policy. Indeed, in a follow-up observation training presentation, Lipp instructed hospitals: "No chest pain patients in Observation," those patients were to be admitted under the Blue Book.

236. Smith and Cash approved the self-serving memorandum while obscuring the nature and extent of the Company's continuing divergence from industry practices and recognized standards of care. On February 29, 2008, ten days after Lipp's memorandum was sent to CHS hospitals, Smith and Cash represented in the Company's 2007 Form 10-K that CHS hospitals were in "substantial compliance" with Medicare and other government regulations and standards (the "Compliance Representation"), without disclosing known facts that called that representation into question.

237. Defendants also made the generalized risk disclosures in the 2007 Form 10-K that if CHS failed to comply with government regulations it could suffer penalties or be required to make significant changes to its operations. However, the generic risk disclosures were themselves misleading in failing to disclose current factual findings, including those detailed by Dr. Zebrowitz less than one month before that created a very specific heightened risk that CHS could be subjected to fines and be required to change its admission practices.

238. Defendants Smith's and Cash's statements support a strong inference that they knew or recklessly disregarded that CHS engaged in improperly aggressive admissions practices, leading to an abundance of one-day stays. During CHS's 2Q 2008 earnings call, Defendant Cash stated: "[O]ne

thing's happened as we had pretty good growth with ER admissions which generally are a little bit less acuity business. So while we've got very good admissions growth, it is a little bit less acuity." Smith then stated:

> One of the things that's maybe driving some of our volume is that we've had an – we've been working hard on these emergency rooms, and increased our emergency room admissions of over 3%, and we are getting a little less acuity in terms of those, and that would be expected when you start really pushing them and working to improve your emergency services.

239. REDACTED. Despite the overwhelming evidence that CHS's "no observation" policy and other ED practices were a compliance risk, Smith's direct involvement in pushing inappropriate admissions and thwarting the less profitable use of observation, continued until the Tenet lawsuit exposed them. Smith denied the effect of the switch to InterQual, and that the criteria was different than the current Blue Book. In November, 2010, Dr. Lynn Simon, Carolyn Lipp's replacement, reported "that there is a concern or a bias against observation units (including WTS)" referring specifically to Defendant Smith to whom she was now a direct report.

6. Smith and Cash Personally Profited by Selling Their CHS Stock at Inflated Prices

240. Strongly indicative of their scienter, Defendants Smith and Cash made significant illegal profits by exercising their stock options and selling the shares during the Class Period after the changes

in the Blue Book that would allow observation (and the consequent decline in ED admissions revenue) were implemented or publicly disclosed. By exercising options and selling shares before this material non-public information could be disclosed, Smith and Cash committed insider trading. The fact that they did so is further evidence of scienter, since it shows Smith and Cash both knew that CHS's profits had been built on improper admissions practices, and that if investors realized that fact, CHS's stock price could plummet, as it later did when Tenet made that fact public for the first time.

241. On April 24, 2009, during a PAB conference call, changes to the 2009 version of the Blue Book were approved, which permitted observation for low level chest pain (rather than admission) for the first time in CHS's history.

242. On May 20, 2009, prior to the implementation of the new policy, or any disclosure of it, Smith exercised vested stock options and sold 250,000 shares at $26.07 per share, yielding $3,267,500 in profits.

243. On August 4, 2009, nine days before the Blue Book change was implemented at CHS hospitals, Cash exercised vested stock options and sold 240,000 shares at $30.79 per share, yielding $2,517,600 in profits.

244. Smith and Cash followed the same pattern of selling in 2010. On March 19, 2010, the Physician Advisory Board - with Smith and Cash in attendance - unanimously approved changes to the Blue Book adding observation for many medical conditions.

These revisions to the Blue Book criteria meant reduced inpatient admissions and reduced revenues.

245. On April 26, 2010, prior to the circulation of the revised Blue Book, Defendant Cash sold 240,000 shares at $40.34 per share, receiving $4,809,600 in profits.

246. Similarly, on May 13 and 14, 2010, Defendant Smith sold 250,000 shares at $41.02 and $40.50 per share, receiving $5,176,408 in profits.

247. On July 15, 2010, the revised Blue Book was circulated to CHS hospitals. As anticipated, admissions declined following the 2009 and 2010 revisions to the Blue Book, as described in ¶¶ 15-16, 370, 464, 466.

248. The timing of these trades by Smith and Cash is strong evidence of scienter because they occurred after the PAB approved revisions to the Blue Book to permit observation for chest pain, but prior to circulating the revised Blue Book to CHS hospitals, which was followed by the inevitable decline of admissions. The suspicious timing of these trades is strong evidence of scienter because Smith and Cash were well aware that CHS admissions were inflated and that, with these changes to the Blue Book, less admission would occur.

249. Finally, the stock options that Defendants Smith and Cash received helped explain why Smith and Cash were willing to use concealed, improper and unlawful steps to boost admissions: the options provided little downside if the Company's underlying shares decline but exponential upside on the rise.

250. Consistent with the findings of a study titled "Throwing Caution to the Wind: The Effect of

C.E.O. Stock Option Pay on the Incidence of Product Safety Problems" by Adam J. Wowak, Michael J. Mannor, and Kaitlin D. Wowak of the Notre Dame Mendoza College of Business, Defendants Smith and Cash were incentivized to take risks recklessly to maximize their personal gains from stock options by aggressively admitting patients even when outpatient observation services were medically sufficient. Smith and Cash then cashed in on the options before the Company's admissions and revenues could be adversely affected by policy changes that they had approved, but of which the investing public was unaware.

7. Smith's and Cash's False Denials and Dissembling of the Facts Underlying Tenet's Claims Support a Strong Inference of Scienter

251. When CHS's conduct was initially exposed by Tenet, the Individual Defendants attempted to temper the market's response by making false and misleading statements, which were inconsistent with CHS's internal documents and, their prior representations, and lacked a reasonable basis in fact.

252. For example, Defendants' repeated representations, after the Tenet exposé, that switching from the Blue Book to InterQual would not have a material impact on its operations were materially false and misleading. Even CHS's incremental changes toward the Blue Book in 2009 and 2010, which attempted to move toward the industry standard, had a negative impact on the Company's inpatient admissions rate. Defendants also knew that lower admissions generally meant

lower Medicare reimbursements for most medical conditions.

253. By way of example:

- Division I President David Miller, acknowledged: "with the recent update and education on the new Blue Book we are seeing an observation admits double. This is having a *devastating impact on our inpatient admits*."
- Division II President Michael Portacci was informed in a March, 2011 memorandum that due to the changes in the Blue Book, at least one hospital had "seen a major increase in observations, up 79 or 91.8% from prior year."
- Division III reported a 30% increase in observations, which was "*wiping out*" there admissions statistics, due to the 2010 changes to the Blue Book.

254. Defendants knew that if incremental changes to the Blue Book caused an admissions downturn, then a wholesale abandonment of the Blue Book and adoption of InterQual, was certain to significantly reduce admissions, as ultimately evidenced on October 26, 2011, when CHS released its 3Q 2011 earnings results.

255. Cash's communications with analysts dismissing the charges made by Tenet support a strong inference that he knowingly misled them about the viability of Tenet's claims, and the impact of the Company's decision to discontinue the Blue Book, in order to temper market response.

256. In CHS's lengthy 112-page presentation dated April 28, 2011, CHS falsely claimed that switching from the Blue Book to InterQual would not have a material impact on its operations. CHS also falsely asserted that Triad's substantial increase in admission rate, and decrease in observations, were attributable to, *inter alia*, "improved case management" and a "strong flu season."

257. Defendants' one-sided response on April 28, 2011 to Tenet's charges supports an inference that they knew or recklessly misled analysts and investors in an effort to assuage the market concerning the impact of discontinuing the Blue Book, CHS's ability to effect its proposed takeover of Tenet, and the Company's potential exposure to the government investigations and fines. *See* ¶ 438, *infra*.

258. In addition, while acknowledging during a May 2, 2011 Deutsche Bank Healthcare Conference call that CHS had recently decided to move from the Blue Book to InterQual, Cash denied that there were significant distinctions between the Blue Book and InterQual, but rather claimed InterQual was "fairly close to our current Blue Book criteria." Cash posited that "rapid changes" would need to be done as CHS transitioned to InterQual, because the Blue Book was based on "current clinical practice."

259. But the Defendants' statements are contradicted by what CHS, Smith and Cash had all known for years – that there were substantial clinical differences between the Blue Book and InterQual which materially impacted CHS's revenues. Debbie Cothern, CHS's Vice President of Quality and Resource Management, wrote an e-mail

on August 6, 2007 to Lipp acknowledging that "there is a tremendous amount of differences between the blue book and interQual" and that "there is no way we can replicate [InterQual]." Lipp recognized this "issue was too hot" and needed answers because she would be briefing the "Senior Management Committee." Even CHS's Chief Medical Officer and member of the PAB wrote that "the Blue Book is just not adequate" in comparison to InterQual.

260. Even after the latest 2010 revisions to the Blue Book, the Chief Nursing Officers continued to report that "there continues to be a difference in the Blue Book to InterQual criteria . . . the Blue Book is not inclusive of the InterQual and therefore patients are not meeting criteria [for admission], especially Blue Cross patients."

261. On January 21, 2011, Lynn Simon observed that Smith "knows that fighting [observation] status is not going to be sustainable …we need to solve this InterQual question first and get the organization on a standardized industry compliant tool."

262. Similarly, during the April 28, 2011 1Q 2011 conference call, as well as during a Bank of America Merrill Lynch Health Care Conference on May 10, 2011, in an obvious attempt to discredit the claims made by Tenet and temper the market, CHS claimed that Pro-MED was "simply a tracking system" and denied that Pro-MED was used as a tool to increase admissions and that the "system does not order tests." However, CHS's internal documents contradicted their position. For example, at Smith's request, the tests ordered for each medical condition were determined, or "locked down," at the corporate level. Smith also directed that corporate track

hospitals' levels of Pro-MED corporate "standardization" and "how compliant [] ED docs are with the Pro-MED system recommendations for admission."

263. After Tenet exposed CHS's improper practices, the Company belatedly disclosed numerous government investigations, lawsuits and shareholder inquiries relating to these same admission and billing practices, including:

(1) the receipt of a subpoena on March 31, 2011 from the U.S. Department of Health and Human Services and OIG, "in connection with an investigation of possible improper claims submitted to Medicare and Medicaid"; and

(2) an investigation commenced by the Office of the Attorney General of the State of Texas on November 15, 2010 concerning the ED procedures and billing for CHS's 18 Texas hospitals which accounted for 15% of the Company's revenues.

264. The foregoing facts therefore, support a strong inference Smith and Cash knowingly or recklessly misled investors about the validity of Tenet's claims in failing to disclose that (1) CHS's successful operating strategies depended on the Company-wide use of the Blue Book's improper admissions justifications; and (2) the Blue Book's improper admissions justifications were responsible in large part for reducing the Triad hospitals' observation rate and increasing their admission rates. Defendants also knew that admissions and

related ED revenues would soften significantly as CHS switched over to InterQual at all its hospitals.

265. These facts, along with the DOJ investigation and CHS's $98 million settlement of that investigation into CHS's admission practices, support an inference of knowing or reckless conduct.

266. A strong inference is warranted from the fact that the "no observation" practice was directed from headquarters and prevalent in multiple hospitals in CHS's divisions. At the top, Lipp candidly promoted the practice "[w]e want to avoid observation as much as possible on Medicare patients" and there should be "no chest patients in observation," rather, all such patients were to be admitted. And, in the face of compliance warnings going back to 2004, the PAB decided to continue excluding observation altogether in January 2005 and for the next five years.

267. It is clear that the "no observation" policy permeated CHS's hospital system. For example:

Division Hospital (State)	**Statement**	**Source**
III Berwick Hospital (PA)	"CEO, ER Director and ER Physician will work toward a goal of ZERO Medicare observations."	CEO
IV Watsonville Hospital (CA)	"almost no medical observation—this is a significant red flag" and that CHS's "no observation" policy created "an environment	Zebrowitz

	of clear medical necessity compliance risk and exposure."	
V Porter Hospital (IN)	the Director of Case Management was "told not to use observation."	Zebrowitz
III Phoenixville Hospital (PA)	"in the ER throughout the day (including weekends)" to make sure ER physicians' "'marching orders' are to admit."	CEO
I Southern Va. Regional Medical Center (VA)	"continued…trend of no observations into 2009" which was a "red flag for CMS and could trigger an audit of short-stay admission patients at the hospital"	Whittaker
I Mid-Atlantic and Southeastern Regions	"evidence of a widespread trend of one-day stays" resulting from CHS's policy of "no Medicare observations" that posed a "significant potential compliance issue relating to the use of observation within our facilities."	Reece

H. Defendants' Additional Material Misstatements and Omissions During the Class Period

268. Throughout the Class Period, Defendants' statements about CHS's operating efficiencies,

growth strategies, quality care and admissions gains were materially false and/or misleading in failing to disclose that, for years, CHS had engaged in a systematic scheme to improperly boost its inpatient admissions through its unsustainable practices discussed above, thereby driving up Medicare reimbursement revenues.

Second Quarter 2006

269. On July 26, 2006, CHS issued a release announcing improved financial results for the second quarter ended June 30, 2006 (the "2Q 2006 Release") as compared to the same period of the prior year. CHS also reported, on a same-store basis, admissions growth of 1.1% and adjusted admissions growth of 0.5%, when compared to the same period of the prior year.

270. In the 2Q 2006 Release, Smith attributed CHS's strong performance to "consistent execution of its centralized and standardized operating strategy," and touted CHS's successful acquisition strategy which "led to greater operating efficiencies while improving [admission] volumes and revenues." These representations were materially false and misleading in failing to disclose the unsustainable admissions practices that enabled CHS to deliver improved results at existing and newly-acquired hospitals. Likewise, Defendants' representation that "our proven ability to deliver improved results…was a distinct competitive advantage" was materially misleading in failing to disclose CHS's unsustainable admissions practices.

271. The 2Q 2006 Release included projections for same hospitals annual admissions growth, net

operating revenues, and other financial metrics derived in part from projected admissions performance. Defendants' projections were materially false and misleading in failing to disclose that they were driven in part by the undisclosed admissions practices discussed above.

272. CHS issued projections in its quarterly earnings releases from 3Q 2006 through 1Q 2011.[10] These projections were materially false and misleading for the same reasons in failing to disclose improper admissions practices which drove the Company's expected growth.

273. On July 27, 2006, CHS held its Q2 2006 earnings conference call. On the call, Smith stated, "Our strong revenue and margin trends through the first half of 2006 validate the strength of our operating model." It was materially false and misleading for Smith to attribute CHS's "strong revenue and margin trends" to the "strength of our operating model" without disclosing its improper admissions practices.

274. On July 28, 2006, the Company filed with the SEC its Form 10-Q for the second quarter of 2006, which was signed by Defendants Smith and Cash (the "2Q 2006 Form 10-Q").

275. The 2Q 2006 Form 10-Q incorporated by reference the risk disclosures from the 10-K of the prior year, which stated "If we fail to comply with extensive laws and government regulations, including fraud and abuse laws, we could suffer

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[10] CHS's earnings releases for 1Q 2007 and 2Q 2007 did not include any projections.

penalties or be required to make significant changes to our operations." However, these risk disclosures materially misled the class members by failing to disclose known risks and unsustainable practices, including (i) the Blue Book, (ii) CHS's "no observation" policy (through August 2009), and (iii) related compliance concerns identified internally and by outside consultants concerning CHS's admissions practices, which created a heightened risk that CHS would be subjected to fines and be required to change its admission practices.

276. From 3Q 2006 through 1Q 2011, CHS made substantially identical representations in each Form 10-Q, incorporating by reference the risk disclosures from the 10-K of the prior year. These risk disclosures were materially false and misleading in failing to disclose known risks and unsustainable practices.

277. Pursuant to the Sarbanes-Oxley Act of 2002 ("SOX"), the 2Q 2006 Form 10-Q included certifications by Smith and Cash, stating that the Q2 2006 Form 10-Q "d[id] not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made… not misleading…"

278. The SOX certifications in the 2Q 2006 Form 10-Q signed by Smith and Cash were materially false and misleading in light of the misleading statements and risk disclosures described in ¶¶ 275, *supra*.

279. From 3Q 2006 through 1Q 2011, each Form 10-Q and each Form 10-K included substantially identical SOX certifications by Smith and Cash,

which were similarly false and misleading in light of misstatements in the SEC filings described herein.

Third Quarter 2006

280. On October 25, 2006, CHS issued a release announcing improved financial results for the third quarter ended September 30, 2006 ("3Q 2006 Release"). CHS reported a 16.9% increase in total inpatient admissions and a 2.6% increase in same-store admissions compared to the same period of the prior year.

281. In the 3Q 2006 Release and 3Q 2006 earnings call held the next day, Smith attributed CHS's improved performance and gain in patient volume and revenue to its "proven centralized operating strategy," and "centralized operating platform and successful integration of our acquired hospitals." These representations were materially false and misleading in failing to disclose that its performance involved the use of improper admissions practices.

282. On October 27, 2006, the Company filed with the SEC its Form 10-Q for the third quarter of 2006, which was signed by Defendants Smith and Cash (the "3Q 2006 Form 10-Q"). The 3Q 2006 Form 10-Q incorporated by reference the risk disclosures, which were materially false and misleading for the same reasons set forth in ¶ 275, *supra*.

283. The SOX certifications in the 3Q 2006 Form 10-Q signed by Smith and Cash were materially false and misleading in light of the misleading statements and risk disclosures described in ¶¶ 275, 277-78, *supra*.

Fourth Quarter and Full Year 2006

284. On November 15, 2006, at a Credit Suisse Boston Healthcare Conference, Defendant Cash stated, "We came to the company in 1997, we had about 2% to 11% of the ER visit became inpatient as a result to adding specialists and adding services and a better management [sic]. We now get about 14% to 15%." Similarly, on November 29, 2006, at a Merrill Lynch Health Service Investor Conference, Defendant Cash stated, "back when we came into the company in 1997 and our 10% or 11% of our ER patients turns into an inpatient admission today is 14% or 15%. We do that by better monitoring the quality and the transfers from our hospitals."

285. Cash's representations about "better monitoring" were materially false and misleading in failing to CHS's unsustainable admissions practices.

286. On February 15, 2007, the Company issued a release announcing improved financial results for the fourth quarter and year ended December 31, 2006. CHS also reported a 15.7% increase in total admissions and a 3.2% gain in same-store admissions compared to 4Q 2005 and a 1.1% gain for the full year.

287. Commenting on the results, CEO Smith misleadingly stated, "Our same store growth metrics are another important measure of our success in 2006 and these favorable trends demonstrate consistent execution of our operating strategy." Smith's representation, touting the Company's "operating strategy" as the source of the improved "same store growth metrics," was materially false

and misleading in failing to disclose its improper admissions practices.

288. On February 20, 2007, the Company filed with the SEC its Form 10-K, which was signed by Defendants Smith and Cash (the "2006 Form 10-K"). In the 2006 Form 10-K, Defendants set forth four components of CHS's business strategy:

- Increase revenue at our facilities;
- Grow through selective acquisitions;
- Improve profitability; and
- Improve quality.

289. Defendants made "Emergency Room Initiatives" the central feature of its revenue strategies:

> Given that over 60% of our hospital admissions originate in the emergency room, we systematically take steps to increase patient flow in our emergency rooms as a means of optimizing utilization rates for our hospitals. …. One component of upgrading our emergency rooms is the implementation of specialized computer software programs designed to assist physicians in making diagnoses and determining treatments.

290. CHS's representations concerning the systematic steps taken as a means of "optimizing utilization rates" were materially false and misleading in omitting that the use of the Blue Book and Pro-MED exposed CHS to significant regulatory risk.

291. CHS also stressed "Case and Resource Management" as a core of its success. Specifically, CHS stated:

> *Case and Resource Management*. Our case and resource management program is a company-devised program developed with the goal of improving clinical care and cost containment. The program focuses on:
>
> * * *
>
> - developing and implementing standards for operational best practices; and
> - using on-site clinical facilitators to train and educate care practitioners on identified best practices.
>
> Our case and resource management program integrates the functions of utilization review, discharge planning, overall clinical management, and resource management into a single effort to improve the quality and efficiency of care. …. [P]atient care begins with a clinical assessment of the appropriate level of care, discharge planning, and medical necessity for planned services.

292. CHS's representations above were materially false and misleading in failing to disclose CHS's unsustainable admission practices developed by CHS and imposed on its hospitals' staffs. Further, Defendants' asserted commitment to best practices and quality care was false and misleading in light of the ethical conflict it forced upon physicians by insisting on its "no observation" edict that forced admissions regardless of a patient's need.

Significantly, Defendants' representations regarding the quality and efficiency of care were materially false and misleading because over-admitting also compromised patient safety; CHS's reports demonstrate that 70% of "hospital acquired conditions" following admission were inflicted upon Medicare patients.

293. Each of CHS's Forms 10-K from 2007 through 2010 included substantially similar representations about CHS's four components of business strategy, which were materially false and misleading for these same reasons.

294. In the 2006 Form 10-K, Defendants also represented that (a) "[w]e share information among our hospital management to implement best practices and assist in complying with regulatory requirements"; (b) "[w]e maintain quality assurance programs to support and monitor quality of care standard and to meet Medicare and Medicaid accreditation and regulatory requirements"; and (c) "[w]e believe that our hospitals are in substantial compliance with current federal, state, and local regulations and standards."

295. However, by late February 2007, Defendants were aware of contemporaneous facts suggesting long-standing Medicare violations (as described in ¶¶ 24-40, 69, 82, 87-92, 143-187, 226-229, *supra*) which were inconsistent with quality of care and best practices, and made Defendants' compliance representations untrue.

296. The 2006 Form 10-K also contained risk disclosures, which stated: "If we fail to comply with extensive laws and government regulations,

including fraud and abuse laws, we could suffer penalties or be required to make significant changes to our operations." However, these risk disclosures themselves were materially misleading in failing to disclose Defendants' knowledge of the heightened risk that CHS would be fined and required to change its admission practices.

297. Each of CHS's Forms 10-K from 2006 through 2010 included substantially similar compliance representations and risk disclosures, which were also materially false and misleading in light of the misstatements described in ¶ 296, *supra*.

298. The SOX certifications in the 2006 Form 10-K signed by Smith and Cash were materially false and misleading in light of the misleading statements and risk disclosures described in ¶¶ 288-92, 294-96, *supra*.

First Quarter 2007

299. On April 25, 2007, the Company issued a release announcing improved financial results for the first quarter ended March 31, 2007, as compared to the same period of the prior year. CHS also reported, on a same-store basis, admissions increased 1.0% and adjusted admissions increased 1.2%, compared to the same period of the prior year.

300. CEO Smith's representations in the 1Q 2007 Release attributing CHS's strong quarterly performance to "proven centralized operating strategy," were materially false and misleading in failing to discuss that its improved results were dependent in large part upon CHS's unsustainable admissions practices, utilizing the Blue Book. For similar reasons, Defendants' statements touting the

"track record of assimilating new hospitals into our system with favorable results" were materially false and misleading in failing to disclose the Company's unsustainable admission practices.

301. On April 26, 2007, the Company filed with the SEC its Form 10-Q for the first quarter of 2007, which was signed by Defendants Smith and Cash (the "1Q 2007 Form 10-Q"). The 1Q 2007 Form 10-Q incorporated by reference the risk disclosures, which were materially false and misleading for the same reasons set forth in ¶ 275, *supra*.

302. In "Management's Discussion and Analysis of Financial Condition and Results of Operations," Defendants similarly represented that CHS's "increase in admissions continues to reflect the application of our operating strategies of growing through selective acquisitions and improving same-store hospital performance." Defendants' attribution was materially false and misleading in failing to disclose that the admissions growth was dependent in large part upon CHS's unsustainable admissions practices, utilizing the Blue Book, which were also used to deliver improved results at newly-acquired hospitals.

303. The SOX certifications in the 1Q 2007 Form 10-Q signed by Smith and Cash were materially false and misleading in light of the misleading statements and risk disclosures described in ¶¶ 275, 277-78, 302, *supra*.

Second Quarter 2007

304. On July 30, 2007, the Company issued a release announcing improved financial results for the second quarter ended June 30, 2007. On a same-

store basis, admissions decreased 0.2% and adjusted admissions decreased 0.4% compared to the same period of the prior year.

305. CEO Smith made similarly misleading representations attributing the Company's solid financial and operating performance to CHS's "consistent execution of our centralized and standardized strategy and our ongoing focus on quality care," while failing to disclose that the Company's success was dependent in large part upon CHS's unsustainable admissions practices, and that those practices compromised patient care. Additionally, Smith's representation regarding CHS's ongoing focus on quality care was materially false and misleading because over-admitting compromised patient safety: CHS's reports demonstrate that 70% of "hospital acquired conditions" following admission were inflicted upon Medicare patients.

306. On July 31, 2007, the Company filed with the SEC its Form 10-Q for the second quarter of 2007, which was signed by Defendants Smith and Cash (the "2Q 2007 Form 10-Q"). The 2Q 2007 Form 10-Q incorporated by reference the risk disclosures, which were materially false and misleading for the same reasons set forth in ¶ 275, *supra*.

307. The same day CHS held a Q2 2007 earnings conference call. On the conference call, CEO Smith discussed potential growth opportunities through the recently announced Triad acquisition:

> We have spent a long period of time, trying to perfect our work in our emergency rooms as it relates to emergency room admissions. We have

> done a lot of good work with that. We have a lot of good systems in place. …. [Triad's] admission rate is lower than ours, which historically you would think would be higher, because generally speaking, they may have hospitals that have a larger number of specialists.

308. The SOX certifications in the Q2 2007 Form 10-Q signed by Smith and Cash were materially false and misleading in light of the misleading statements and risk disclosures described in ¶¶ 275, 277-78, *supra*.

309. Smith's discussion of "the good systems in place" in the ED was materially false and misleading in failing to disclose CHS's unsustainable admissions practices. It was also misleading to feign surprise at lower admissions rates at the Triad hospitals relative to the legacy CHS hospitals. Defendants gave the misleading impression that CHS's admissions rates outpaced Triad due to the exceptional ED systems it had in place without disclosing the unsustainable admissions practice that had contributed to CHS's higher rates.

Third Quarter 2007

310. On October 30, 2007, CHS issued a release announcing results for the third quarter ended September 30, 2007. As to the Triad acquisition, CEO Smith touted CHS's "proven track record for finding suitable hospitals and successfully assimilating these facilities into our system," which it attributed to "an effective centralized and standardized operating platform." However, Smith failed to disclose that unsustainable admission

practices enabled CHS to deliver improved results at newly-acquired hospitals, including Triad.

311. On November 2, 2007, the Company filed with the SEC its Form 10-Q for the third quarter of 2007, which was signed by Defendants Smith and Cash (the "3Q 2007 Form 10-Q"). The 3Q 2007 Form 10-Q incorporated by reference the risk disclosures, which were materially false and misleading for the same reasons set forth in ¶ 275, *supra*.

312. The SOX certifications in the 3Q 2007 Form 10-Q signed by Smith and Cash were materially false and misleading in light of the misleading statements and risk disclosures described in ¶¶ 275, 277-78, *supra*.

Fourth Quarter and Full Year 2007

313. CEO Smith discussed the integration of Triad hospitals at a Credit Suisse China Healthcare Conference held on November 13, 2007. Smith emphasized the "area that we found opportunity in historically for our hospitals has been our emergency services, and we work on our emergency services in terms of standardizing and centralizing our approach." Smith's representation was materially false and misleading because he failed to disclose the unsustainable admission practices used in standardizing and centralizing ED services at existing and newly-acquired hospitals, which accounted for CHS's success.

314. On February 21, 2008, the Company issued a release announcing its financial results for the fourth quarter ended December 31, 2007 (the "2007 Release"). In the 2007 Release, Defendants reiterated that CHS "remains focused on the key

areas for success in its business — an effective centralized and standardized operating platform, effective cost management, a successful physician recruitment program and a favorable reputation in the marketplace." CEO Smith also stated, "We intend to build on our past success as a proven operator and leverage these assets to further extend our record of growth."

315. On February 28, 2008, the Company filed its 2007 annual report on Form 10-K, which was signed by Smith and Cash (the 2007 Form 10-K").

316. In the 2007 Form 10-K, Defendants made representations regarding compliance with federal, state and local regulations and standards essentially identical to the representations made in the 2006 Form 10-K as set forth in ¶¶ 294-95, *supra*. Defendants' representations that CHS hospitals were in substantial compliance with regulatory requirements were materially false and misleading in failing to disclose material contemporaneous facts suggesting long-standing potential Medicare violations at numerous hospitals, as set forth in ¶¶ 24-57, 59, 69-70, 74-79, 82-96, 143-187, 202-203, 216-218, 220-222, 226-229.

317. The 2007 Form 10-K contained risk disclosures stating, "If we fail to comply with extensive laws and government regulations, including fraud and abuse laws, we could suffer penalties or be required to make significant changes to our operations," which were materially false and misleading for the same reasons set forth in ¶ 296, *supra*.

318. The 2007 Form 10-K also contained representations regarding (i) the Emergency Room Initiatives, and (ii) Case and Resource Management, which were essentially identical to the representations made in 2006 Form 10-K as set forth in ¶¶ 288-92. These representations were also materially false and misleading in failing to disclose CHS's unsustainable admission practices in the ED by using Pro-MED and the Blue Book, and also in failing to disclose the conflict CHS created between its stated commitment to quality healthcare and efficiency and its goal of boosting revenues through improper admissions using unsustainable admissions practices.

319. The SOX certifications in the 2007 Form 10-K signed by Smith and Cash were materially false and misleading in light of the misleading statements and risk disclosures described in ¶¶ 288-92, 294-96, 315-18, *supra*.

First Quarter 2008

320. At a JP Morgan Chase & Co. Healthcare Conference on January 9, 2008, Smith described CHS's "simple" strategy, which he "articulate[d] very straight forwardly" -- "building market share" through "recruiting physicians [and] improving operations [and] expanding services [and] renovating facilities and upgrading facilities…"

321. Similarly, at the March 4, 2008 Raymond James Institutional Investors Conference, Cash stated that CHS spent probably about "$140 million on 42 ER renovations," and noted that when "[w]e came to this company about 10 years ago, the admit rate through the ER was about 10%, now it's about

15%." Cash also gave some of the credit to Pro-MED, which he described as "a standard data tracking system," stating "Pro-MED is in all our hospitals, and we've put that in the Triad hospitals."

322. Smith's representations that CHS was forthright about the reasons for its success were materially misleading in failing to disclose that CHS's success was dependent in large part upon the unsustainable admissions practices, including the use of Pro-MED, which incorporated improper admissions criteria, to deliver improved results. Smith's descriptions of Pro-MED as a "standard data tracking system" were also materially incomplete in minimizing its function, for the reasons set forth in ¶¶ 42-49, *supra*, (test-mapping).

323. On March 18, 2008, at the Lehman Brothers Global Healthcare Conference, Smith stated "we have a lot of opportunities in terms of margin improvements from the Triad acquisition. We have absolutely a strong record." Smith's representation was materially false and misleading in failing to disclose that CHS's success was dependent in large part upon the unsustainable admission practices that enabled CHS to deliver improved results at newly-acquired hospitals.

324. On April 29, 2008, CHS issued a release announcing improved financial results for the first quarter ended March 31, 2008, as compared to the same period of the prior year ("1Q 2008 Release"). The Company reported, on a same-store basis, admissions growth of 3.8% and adjusted admissions growth of 3.8%, when compared to the same period of the prior year.

325. In the 1Q 2008 Release, Smith attributed CHS's improved performance to "our ability to drive revenue and improve the operating performance of both our existing and recently acquired facilities." Generally, Smith cited "an effective centralized and standardized operating platform" as underlying a key area of CHS's success.

326. Similarly, in the 1Q 2008 earnings call held on April 30, 2008, Smith attributed CHS's increase in admission volume in part to the "strong flu benefit" as well as the extra day in February.

327. Smith's representations attributing CHS's solid performance to the flu and the extra day caused by the leap year were materially misleading in failing to disclose that CHS's success was due in large part to CHS's unsustainable admissions practices. Likewise, Smith failed to disclose the Company's centralized and standardized operating platform was driven in part by the Blue Book and "no observation" strategies.

328. On May 2, 2008, the Company filed with the SEC its Form 10-Q for the first quarter of 2008, which was signed by Defendants Smith and Cash (the "1Q 2008 Form 10-Q"). The 1Q 2008 Form 10-Q incorporated by reference the risk disclosures, which were materially false and misleading for the same reasons set forth in ¶ 275, *supra*.

329. The SOX certifications in the 1Q 2008 Form 10-Q signed by Smith and Cash were materially false and misleading in light of the misleading statements and risk disclosures described in ¶¶ 275, 328-29, *supra*.

Second Quarter 2008

330. On June 11, 2008, at the Goldman Sachs Healthcare Conference, Smith discussed the acquisition and integration of Triad's hospitals stating "[w]e're in a good solid operating mode now, and we should start beginning to see performance as we go forward, improved performance."

331. Smith's foregoing representations regarding the "good solid operating mode" at Triad and that "we don't know of any systemic issues related to volume," boasting that CHS believed it had "the best opportunity for growth in this industry" were materially misleading in failing to disclose facts recently communicated to senior management suggesting huge compliance risks, ¶¶ 6, 24-35, 105-107, *supra*, CHS's "no observation" policy and use of the Blue Book at new and existing hospitals. For these reasons, Defendants' claim that CHS had the "best opportunity for growth in this industry," was materially misleading. Indeed, once CHS's operations fraud was exposed, its expansion opportunities nearly vanished. During 2011, CHS acquired only 1 hospital and only 4 hospitals during 2012.

332. On July 28, 2008, CHS issued a release announcing its financial results for the second quarter ended June 30, 2008 ("2Q 2008 Release"). On a same-store basis, CHS reported admissions increased 2.3% and adjusted admissions increased 2.4%, compared to the same period of the prior year.

333. In the 2Q 2008 Release, Smith claimed that CHS's improved results "reflect[ed] consistent execution of our strategy and our continued progress

with respect to the integration of the significant number of facilities acquired in 2007." Smith cited CHS's proven business model for improving the operating performance at both its existing and acquired facilities."

334. Smith's representations attributing CHS's operating performance to "consistent execution of our strategy and our continued progress with respect to the integration" of the facilities acquired in 2007 were materially false and misleading in failing to disclose that CHS's success was dependent in large part upon the unsustainable admission practices.

335. On July 29, 2008, CHS held its 2Q 2008 earning conference call. On the call, Cash noted "we had pretty good growth with ER admissions which are generally a little bit less acuity business. So while we've got very good admissions growth, it is a little bit less acuity." Smith echoed this sentiment, stating "[o]ne of the things that's maybe driving some of our volumes is that we've had an – we've been working hard on these emergency rooms, and increased our emergency rooms [] over 3%, and we are getting a little less acuity in terms of those, and that would be expected when you start really pushing them and working to improve your emergency services."

336. Cash's representations regarding the Company getting maximum use of its emergency rooms while ensuring appropriate admissions was materially false and misleading in light of the fact that CHS implemented a policy of increasing inpatient admissions and decreasing observations based on improper admissions criteria.

337. On August 5, 2008, the Company filed with the SEC its Form 10-Q for the second quarter of 2008, which was signed by Defendants Smith and Cash (the "2Q 2008 Form 10-Q"). The 2Q 2008 Form 10-Q incorporated by reference the risk disclosures, which were materially false and misleading for the same reasons set forth in ¶ 275, *supra*.

338. The SOX certifications in the 2Q 2008 Form 10-Q signed by Smith and Cash were materially false and misleading in light of the misleading statements and risk disclosures described in ¶¶ 275, 277-78, *supra*.

Third Quarter 2008

339. On October 29, 2008, CHS issued a release announcing financial results for the third quarter ended on September 30, 2008 ("3Q 2008 Release"). On a same-store basis, the Company reported admissions increased 2.3% and an adjusted admissions increased 2.5%, when compared to the same period of the prior year.

340. On October 31, 2008, the Company filed its Form 10-Q, which was signed by Smith and Cash. The 3Q 2008 Form 10-Q incorporated by reference the risk disclosures, which were materially false and misleading for the same reasons set forth in ¶ 275, *supra*.

341. The SOX certifications in the 3Q 2008 Form 10-Q signed by Smith and Cash were materially false and misleading in light of the misleading statements and risk disclosures described in ¶¶ 275, 277-78, *supra*.

342. On November 9, 2008, at the Morgan Stanley Global Healthcare Unplugged Conference,

Cash stated "one of the things we work very hard [on] is trying to get maximum use of emergency room and appropriate admissions through there." Cash also discussed installing and utilizing Pro-MED in the Triad hospitals, making substantially similar representations to those stated herein.

343. Cash's representations regarding the Company getting maximum use of its emergency rooms, while ensuring appropriate admissions was materially false and misleading in light of the fact that CHS implemented a policy of increasing inpatient admissions and decreasing observations based on improper admissions criteria. Cash's representations regarding Pro-MED were materially false and misleading for the reasons discussed in ¶¶ 36-49.

Fourth Quarter and Full Year 2008

344. On February 19, 2009, CHS issued a release announcing its improved financial results for the fourth quarter and year ended December 31, 2008. On a same-store basis, the Company reported admissions growth of 2.0% and adjusted admissions growth of 42.1% compared to the prior year.

345. On February 20, 2009, CHS held its 4Q 2008 earnings call, during which Smith touted CHS's "very strong year" for same-store admissions, which were "higher than anybody else in the country." Defendants' representations about CHS's success in admissions growth and ER management were false and misleading in failing to disclose the fact that CHS's success was dependent in large part upon the undisclosed and unsustainable improper admissions practices.

346. On February 27, 2009, the Company filed with the SEC its Form 10-K, which was signed by Smith and Cash (the "2008 Form 10-K").

347. In the 2008 Form 10-K, Defendants made representations regarding compliance with federal, state and local regulations and standards essentially identical to the representations made in 2006 Form 10-K as set forth in ¶¶ 294-95, *supra*. Defendants' representations that CHS hospitals were in substantial compliance with regulatory requirements were materially false and misleading in failing to disclose material contemporaneous facts suggesting long-standing potential Medicare violations at numerous hospitals, as set forth in ¶¶ 24-57, 59-60, 69-70, 73-104, 138, 140-141, 143-187, 216-222, 226-238.

348. The 2008 Form 10-K contained risk disclosures stating, "If we fail to comply with extensive laws and government regulations, including fraud and abuse laws, we could suffer penalties or be required to make significant changes to our operations," which were materially false and misleading for the same reasons set forth in ¶ 296, *supra*.

349. The 2008 Form 10-K also contained representations regarding (i) the Emergency Room Initiatives, and (ii) Case and Resource Management, which were essentially identical to the representations made in the2006 Form 10-K as set forth in ¶¶ 288-92, *supra*.

350. These representations were also materially false and misleading in failing to disclose CHS's unsustainable admission practices in the ED by

using Pro-MED and the Blue Book, and also in failing to disclose that CHS's commitment to quality healthcare and efficiency were compromised by its goal of boosting revenues by unsustainable admissions practices.

351. The SOX certifications in the 2008 Form 10-K signed by Smith and Cash were materially false and misleading in light of the misleading statements and risk disclosures described in ¶¶ 288-92, 294-96, 347-50, *supra*.

First Quarter 2009

352. On April 23, 2009, CHS issued a release announcing its financial and operating results for the first quarter ended March 31, 2009 (the "1Q 2009 Earnings Release"). On a same-store basis, admissions decreased 4.9% and adjusted admissions decreased 2.4%, compared with the same period in 2008.

353. In the 1Q 2009 Earnings Release, Smith described CHS's first quarter performance this way:

> We are pleased with our solid financial performance for the first quarter of 2009. *These results reflect our proven operating strategy and our ability to drive revenues and improve the financial performance of our hospitals* in spite of a challenging operating environment. We will continue to manage our operations as efficiently as possible in this uncertain economy and, at the same time, *meet our commitment to provide quality healthcare* in the communities we serve.

(Emphasis added).

354. Smith's representations attributing the solid financial performance to "our proven operating strategy and our ability to drive revenues and improve the financial performance of our hospitals" were materially false and misleading in failing to disclose that the Company's performance was dependent in large part upon CHS's unsustainable admissions practices, utilizing the Blue Book. Additionally, Smith's representation that CHS would continue to "meet our commitment to provide quality healthcare" was materially false and misleading in failing to disclose that CHS's commitment to provide quality healthcare was compromised by CHS's commitment to boosting revenues by unsustainable admissions practices. Moreover, Smith's representation regarding CHS's commitment to provide quality healthcare was materially false and misleading because over-admitting also compromised patient safety.

355. On April 29, 2009, the Company filed with the SEC its Form 10-Q for the first quarter of 2009, which was signed by Smith and Cash (the "1Q 2009 Form 10-Q"). The 1Q 2009 Form 10-Q incorporated by reference the risk disclosures, which were materially false and misleading for the same reasons set forth in ¶ 275, *supra*.

356. The SOX certifications in the 1Q 2009 Form 10-Q signed by Smith and Cash were materially false and misleading in light of the misleading statements and risk disclosures described in ¶¶ 275, 277-78, 356, *supra*.

Second Quarter 2009

357. On July 30, 2009 CHS issued a release announcing its financial and operating results for the second quarter ended June 30, 2009 (the "2Q 2009 Release"). On a same-store basis, admissions decreased 0.4% and adjusted admissions increased 1.7%, compared with the same period in 2008.

358. In the 2Q 2009 Release, Smith touted the ability of CHS's "proven operating model [to] favorable support our business" despite adverse economic trends that put the hospital industry volumes under pressure. This representation was materially false and misleading in failing to disclose that CHS's ability to positively impact volumes was dependent in large part upon the unsustainable admissions practices.

359. On July 31, 2009, the Company filed with the SEC its Form 10-Q, signed by Defendants Smith and Cash (the "2Q 2009 Form 10-Q"). 2Q 2009 Form 10-Q incorporated by reference the risk disclosures, which were materially false and misleading for the same reasons set forth in ¶ 275, *supra*.

360. The SOX certifications in the 2Q 2009 Form 10-Q signed by Smith and Cash were materially false and misleading in light of the misleading statements and risk disclosures described in ¶¶ 275, 277-78, 360, *supra*.

Third Quarter 2009

361. On October 28, 2009, CHS issued a release announcing its financial and operating results for the third quarter and nine months ending September 30, 2009 (the "3Q 2009 Release"). On a same-store basis, admissions decreased 0.2% and adjusted admissions

increased 1.9%, compared with the same period in 2008.

362. In the 3Q 2009 Release, CEO Smith proclaimed that CHS "again exceed[ed] expectations," which he attributed to "favorable revenue trends," noting that "the fundamentals of our business are strong and our centralized operating strategy is working across all of our markets." Smith, however, failed to disclose that CHS's favorable revenue trends and operating performance was dependent in large part upon the unsustainable admissions practices.

363. On September 10, 2009, Defendant Cash, speaking at a Robert W. Baird & Co. Health Care Conference, discussed CHS's ER strategy with respect to newly acquired Triad hospitals:

> Another strategy is ER. We get about 55 to 60% of our admissions [through] the ER. When we came to the company about 12 years ago, the admission rate out of ER was 10, 11%. Now it's 15%. Actually, the Triad hospitals had an admit rate which was lower than the CHS, and we've improved that admit rate so far. And a mid-sized market should have a little better admit rate.

364. Cash's foregoing representations were materially false and misleading in failing to disclose that the higher admission rate at CHS was due in part to implementing unsustainable admissions practices.

365. CHS's Form 10-Q for the third quarter of 2009, signed by Smith and Cash (the "3Q 2009 Form 10-Q") was materially misleading because it

incorporated by reference the risk disclosures, which were materially false and misleading for the same reasons set forth in ¶ 275, *supra*.

366. The SOX certifications in the 3Q 2009 Form 10-Q signed by Smith and Cash were materially false and misleading in light of the misleading statements and risk disclosures described in ¶¶ 275, 277-78, 365, *supra*.

Fourth Quarter and Full Year 2009

367. On February 17, 2010, CHS issued a release announcing its financial and operating results for the fourth quarter ended December 31, 2009 (the "4Q 2009 Release"). On a same-store basis, admissions decreased 0.5% and adjusted admissions increased 1.6%, compared with the same period in 2008.

368. Commenting on the year end results, CEO Smith stated:

> Our results also reflect the continued success of our centralized operating strategy as evidenced by favorable annual same-store revenue growth and solid margin expansion. We have continued to focus on improving the performance at the individual hospital level in all of our markets, especially at our more recently acquired facilities.

369. Smith's representation attributing record results to "the continued success of our centralized operating strategy" was materially false and misleading in failing to disclose that CHS's success was dependent in large part upon unsustainable admissions practices, which was also used to deliver improved results at newly-acquired hospitals.

370. On February 18, 2010, during the 4Q 2009 earnings call, Cash addressed the decrease in same-store admissions, stating, "we did see a decline in one-day stays that affects inpatient volume and a corresponding increase in outpatient observation visits." The statement was materially misleading because Cash failed to disclose the fact that this reduction in one-day stays was a result of the changes made to the 2009 version of the Blue Book, which for the first time allowed observation for one condition: chest pain.

371. On February 26, 2010, the Company filed with the SEC its Form 10-K, which was signed by Smith and Cash (the "2009 Form 10-K").

372. In the 2009 Form 10-K, Defendants made representations regarding compliance with federal, state and local regulations and standards essentially identical to the representations made in 2006 Form 10-K as set forth in ¶¶ 294-95, *supra*. Defendants' representations that CHS hospitals were in substantial compliance with regulatory requirements were materially false and misleading in failing to disclose material contemporaneous facts suggesting long-standing potential Medicare violations at numerous hospitals, as set forth in ¶¶ 24-57, 59-62, 69-70, 73-106, 133, 138, 140-187, 204-210, 216-222, 226-238.

373. The 2009 Form 10-K contained risk disclosures stating, "If we fail to comply with extensive laws and government regulations, including fraud and abuse laws, we could suffer penalties or be required to make significant changes to our operations," which were materially false and

misleading for the same reasons set forth in ¶ 296, *supra*.

374. The 2009 Form 10-K also contained representations regarding (i) the Emergency Room Initiatives, and (ii) Case and Resource Management, which were essentially identical to the representations made in 2006 Form 10-K as set forth in ¶¶ 288-92, *supra*. These representations were also materially false and misleading in failing to disclose CHS's unsustainable admission practices in the ED by using Pro-MED and the Blue Book, and also in failing to disclose that CHS's commitment to quality healthcare and efficiency were superseded by its goal of boosting revenues by unsustainable admissions practices.

375. The SOX certifications in the 2009 Form 10-K signed by Smith and Cash were materially false and misleading in light of the misleading statements and risk disclosures described in ¶¶ 288-92, 294-96, 372-74, *supra*.

First Quarter 2010

376. On April 21, 2010, CHS issued a release announcing its financial and operating results for the first quarter ended March 31, 2010 (the "1Q 2010 Release"). In the 1Q 2010 Release, Smith represented that "[o]ur success as an operator is supported by consistent growth in revenues and earnings, in spite of a challenging economic environment. These results confirm that the fundamentals of our business are strong and our centralized operating strategy is working across our markets."

377. Smith's representations attributing the consistent growth in revenues and earnings to CHS's "success as an operator," strong fundamentals, and "our centralized operating strategy" are materially false and misleading in failing to disclose that CHS's performance was dependent in large part upon the unsustainable admissions practices.

378. On April 22, 2010, CHS held its 1Q 2010 earnings conference call. On the call, Cash reported that same-store admissions decreased 1.2%, due in part to "reductions in one-day stays with a corresponding increase in outpatient observations." Cash made similar representations at a May 5, 2010 Deutsche Bank Securities Health Care Conference.

379. This reduction in one-day stays resulted from a modest revision to the Blue Book. Cash's representation was materially misleading in failing to disclose the fact that even with the revision, the Blue Book's criteria generally still diverged significantly from the industry standard.

380. On April 28, 2010, the Company filed with the SEC its Form 10-Q for the first quarter of 2010, which was signed by Defendants Smith and Cash (the "1Q 2010 Form 10-Q"). The 1Q 2010 Form 10-Q also incorporated by reference the risk disclosures, which were materially false and misleading for the same reasons set forth in ¶ 275, *supra*.

381. The SOX certifications in the 1Q 2010 Form 10-Q signed by Smith and Cash were materially false and misleading in light of the misleading risk disclosures described in ¶¶ 275, 277-78, 379, *supra*.

382. On May 11, 2010, at a Bank of America Merrill Lynch Healthcare Conference, Smith stated:

> In 2010, our admissions from our emergency rooms are up from 15.5% to 16.1% so that's up from about 11% if you go back a number of years kind of going forward. Our same store visits, I stumbled on this, was 2.3% this year. One of the things that we do and is sort of the backbone of our organization is we have a standardized, centralized platform. This is the reason that we have very consistent earnings and our performance is very consistent. ….You look down this list, everything on here is a standardized, centralized function that we have in place. It's very good in terms of consistency of performance. It's all about process improvement, best practices. It's great for regulatory compliance and it's really good for good governance.

383. Smith's foregoing representations, attributing CHS's consistent earnings and performance to the "standardized, centralized platform," which was "great for regulatory compliance," were materially false and misleading in failing to disclose that CHS's performance was dependent in large part upon unsustainable admissions practices.

Second Quarter 2010

384. On July 28, 2010, CHS issued a release announcing its financial and operating results for 2Q 2010 (the "2Q 2010 Earnings Release"). Smith highlighted that CHS's "consistent execution of our centralized operating strategy" had "continue[d] to drive revenues and achieve solid margins" and that the Company "consistently demonstrated our ability to deliver favorable operating results through our

efforts to implement best practices in all of our hospitals."

385. Smith's representations were materially false and misleading in failing to disclose that CHS's operating strategy and ability to deliver favorable operating results were dependent in large part upon the unsustainable admissions practices.

386. In the 2Q 2010 earnings call held on July 29, 2010, Cash reported "same-store admissions decreased 2.5%" due in part to "a reduction in one-day admissions with a corresponding increase in outpatient observation of 70 basis points." This representation was misleading in failing to disclose that one-day stays declined due to revisions of the Blue Book, which allowed for observation.

387. On July 30, 2010, the Company filed with the SEC its Form 10-Q for the second quarter of 2010, which was signed by Defendants Smith and Cash (the "2Q 2010 Form 10-Q"). The 2Q 2010 Form 10-Q incorporated by reference the risk disclosures from the 2009 Form 10-K, which were materially false and misleading for the reasons set forth in ¶ 275, *supra*.

388. The SOX certifications in the 2Q 2010 Form 10-Q signed by Smith and Cash were materially false and misleading in light of the misleading statements and risk disclosures described in ¶¶ 275, 277-78, 386, *supra*.

Third Quarter 2010

389. On October 27, 2010, CHS issued a release announcing its financial results for the third quarter ended September 20, 2010 (the "3Q 2010 Release"). On a same-store basis, admissions decreased 3.6%

and adjusted admissions decreased 1.3%, compared with the same period in 2009.

390. In commenting on the results, CEO Smith stated:

> We are pleased with our solid financial performance for the third quarter of 2010, in what has continued to be a challenging economic environment. Our conservative operating strategy and strong focus on expense management have served us well. *We continue to benefit from a consistent performance at the hospital level, as evidenced by favorable same-store revenue trends for the third quarter and year to date periods.*

Throughout 2010, we have continued to extend our market reach through selective acquisitions. We have identified hospital facilities that meet our operating profile with the most opportunity for growth. *We have a proven track record for the successful integration of these facilities with improved operating results.*

(Emphasis added).

391. Smith's representations touting CHS's consistent performance as "evidenced by same-store [hospital] revenue trends" and its "proven track record for the successful integration of these [acquisition targets] with improved operating results" were also materially false and misleading in failing to disclose the unsustainable admissions practice used to achieve improved revenue trends and operating results.

392. On October 28, 2010, CHS held its 3Q 2010 earnings conference call. As in the prior two quarters

of 2010, Cash reported that same-store admissions decreased 3.6% due in part to a "reduction[ ] in one-day stays with the corresponding increase in outpatient observations."

393. In its 3Q 2010 Form 10-Q filed the next day, CHS explained that the "decrease in inpatient admissions was due primarily to … a less severe flu season as compared to the prior year period, lower birth rates driven by the downturn in the economy, reductions in one day stays and certain service closures during the three months ended September 30, 2010, as compared to the three months ended September 30, 2009." The 3Q 2010 Form 10-Q incorporated by reference the risk disclosures from the 2009 Form 10-K, were materially false and misleading for the same reasons set forth in ¶ 297, *supra*.

394. Defendants' representations were materially false and misleading in failing to disclose the fact that this reduction in one-day stays was attributable in large part to the recent revision of the Blue Book, which allowed for observation for some medical conditions. The result, as described in ¶¶ 252-53, *supra*, was that CHS hospitals saw "observation admits double," "wiping out admissions statistics."

395. The SOX certifications in the 3Q 2010 Form 10-Q signed by Smith and Cash were materially false and misleading in light of the misleading statements and risk disclosures described in ¶¶ 275, 277-78, 393-94, *supra*.

Fourth Quarter and Full Year 2010 CHS's Attempt to Takeover Tenet

396. On December 9, 2010, CHS issued a press release publicly announcing a cash-and-stock proposal to acquire Tenet at $6.00 per share. In the press release, which was filed with the SEC, CHS stated, *inter alia*, that CHS had a "reputation for superior operating performance and a successful track record of integrating acquisitions."

397. CHS included Smith's December 9, 2010 letter to Tenet's Board of Directors, which questioned the Board's rejection of a "substantial premium" offer and touted CHS's "extremely successful acquisition and integration track record, most notably evidenced by our acquisition of Triad Hospitals in 2007."

398. CHS attached to its press release a presentation entitled "Community Health Systems and Tenet Healthcare: A Compelling Opportunity For Value Creations." In a slide entitled "CHS Management Team Has a Proven Track Record of Superior Operating Performance," CHS stated its average annual same-facility revenue growth from 2008 to 2010 was 5.4%, outpacing Tenet's 4.1%.

399. The statements in ¶¶ 396 to 398 were materially false and misleading in light of CHS's failure to disclose that CHS's superior operating performance was the product of CHS's improper practices, discussed in detail above, to drive patient admissions despite the absence of a clinical basis for these patients to be admitted into the hospital. These unsustainable practices exposed Medicare and other payers to millions of dollars of improper additional costs. CHS's purported reputation as a

successful operator and acquirer was based on the same improper conduct.

400. CHS continued to tout its proven operating strategy and acquisition track record, with special emphasis on Triad. On December 10, 2010, in an analyst call to discuss CHS's proposed acquisition of Tenet, Defendant Smith touted CHS's "proven track record of unmatched operating performance," including through CHS's acquisition of Triad, which CHS "successfully integrated."

401. On December 20, 2010, CHS announced that it was commencing a proxy contest to take control of Tenet's Board of Directors at Tenet's upcoming 2011 annual meeting.

402. On January 11, 2011 at the J.P. Morgan Healthcare Conference, Smith discussed, *inter alia*, CHS's offer to buy Tenet as well as CHS's business strategy:

> So when you think about us, we think we have a very clear executable strategy. It's predictable. It's sustainable, as we've proven over the last 10 years…And definitely we've a proven operating permanent strategy that works with consistent financial performance and margin improvement.

403. During the January 11th conference, Smith stated that CHS is an "Industry Leader in Admissions Growth," and provided data showing that CHS's admissions and adjusted patient admissions had grown in every year from 2000 to 2009. In addition, CHS stated that one of its "Significant Opportunities for Growth in Revenue and Operating Profit" is to "Increase Inpatient ER Visits." CHS further stated that its "ER Strategy"

has "[c]ontributed to same store admission growth." Smith also boasted that "we've improved [Triad's] margin about 280 basis points."

404. On February 8, 2011, Defendant Smith delivered a presentation at the UBS Global Healthcare Services Conference; excerpts of Smith's remarks at the UBS conference were filed with the SEC. These materials contained similar material misstatements as Smith made in prior healthcare conferences. For example, Smith touted CHS's ability to improve margins and performance in its acquired hospitals, citing the Triad acquisition as the primary example, and observed that the investment community has favorably received CHS's proposed acquisition of Tenet.

405. The statements in ¶¶ 400 to 403 were materially false and misleading in light of CHS's failure to disclose that its same-store admissions growth, ER strategy, operating strategy and successful integration of Triad depended in large part on CHS's improper admissions practices, discussed in detail above.

2010 Year-End Results

406. On February 24, 2011, CHS issued a release announcing improved financial and operating results for the three months and year ending December 31, 2010 (the "Q4 2010 Earnings Release"). The Company reported a 2.0% increase in total admissions, a 5.1% increase in total adjusted admissions, and a 1.5% decrease in same-store admissions, compared to the same period of the prior year.

407. Commenting on the 2010 results, CEO Smith touted, "[o]ur consistent pattern of growth reflects our success as an operator, especially in what has continued to be a challenging economic environment."

408. On February 25, 2011, the Company filed its 2010 Form 10-K, which was signed by CEO Smith and CFO Cash (the "2010 Form 10-K").

409. In the 2010 Form 10-K, Defendants made representations regarding compliance with federal, state and local regulations and standards essentially identical to the representations made in 2006 Form 10-K as set forth in ¶¶ 294-95, *supra*. Defendants' representations that CHS hospitals were in substantial compliance with regulatory requirements were materially false and misleading in failing to disclose the material contemporaneous fact that the revised Blue Book was still significantly divergent from the industry standard, creating a heightened risk for compliance violations, as set forth in ¶¶ 24-62, 65-106,133, 138, 140-187, 204-210, 216-239.

410. The 2010 Form 10-K contained risk disclosures stating, "If we fail to comply with extensive laws and government regulations, including fraud and abuse laws, we could suffer penalties or be required to make significant changes to our operations," which were materially false and misleading for the same reasons set forth in ¶ 296, *supra*.

411. The 2010 Form 10-K also contained representations regarding (i) the Emergency Room Initiatives, and (ii) Case and Resource Management, which were essentially identical to the

representations made in 2006 Form 10-K as set forth in ¶¶ 288-92, *supra*. These representations were also materially false and misleading in failing to disclose CHS's unsustainable admission practices in the ED by using Pro-MED and the Blue Book, and also in failing to disclose that CHS's commitment to quality healthcare and efficiency were superseded by its goal of boosting revenues by unsustainable admissions practices.

412. The SOX certifications in the 2010 Form 10-K signed by Smith and Cash were materially false and misleading in light of the misleading statements and risk disclosures described in ¶¶ 288-92, 294-96, 409-11, *supra*.

413. The same day CHS held a fourth quarter 2010 earnings call. On the call, Cash reported that same-store admissions decreased 2.8% due in part to "reductions in one-day stays with a corresponding increase in outpatient observations." Smith suggested, however, that the trend away from inpatient stays would have little impact on CHS's revenues given that "there are certain insurance companies that payment on observation is essentially the same as when [patients] stay."

414. Smith reiterated that the trend was "an industry-wide issue, and I don't see anything that's problematic for us…It's just a change in location basically." He also touted CHS's "success as an operator and consolidator in the industry."

415. The foregoing representations were materially misleading and incomplete because Smith failed to disclose that the reduction in one-day stays was not due simply to pressure from managed care

providers, but also, in large part, to revisions to the Blue Book adding observations. For example, an October 2010 Weekly Management Report for Fannin Regional Hospital noted that the "recent update" to the Blue Book, which involved adding observation criteria for the first time, caused the hospital's "observation admits to double," which had a "devastating impact on our inpatient admits."

416. Moreover, Smith's suggestion that there was little cost differential to the payor between billing for a one-day stay as opposed to observation, and that the difference between an admission and observation was merely a change in "location," was materially misleading in creating the false impression that the reimbursement amount for admissions and observations were equivalent when Medicare typically reimbursed far less for observation. Despite Smith's claimed treatment by a few insurers, Medicare and other payors rarely paid as much for observation as for admissions. CHS acknowledges this "was the exception rather than the rule."

417. Defendants also misleadingly characterized the shift as merely "a change in location," *i.e.*, from admission to observation units, when, in fact, CHS hospitals were far more vulnerable than their peers in the industry to pressure from payors to shift admitted patients to observation status because CHS had vastly underutilized observation status by design as compared to CHS's peer hospital operators.

418. On March 1, 2011, Smith delivered a presentation at the Citi Global Healthcare Conference. The presentation and excerpts of Smith's remarks were filed with the SEC. These

materials contained numerous materially false and misleading statements, similar to those contained in the JP Morgan Investor Conference on January 11, 2011. Smith also misleadingly touted CHS's ability to improve margins and performance in its acquired hospitals, citing the Triad acquisition as the primary example.

419. Smith's statements concerning CHS's success as an acquirer and its operational performance were misleading in failing to disclose CHS's admission practices on which it success depended.

The Truth Emerges Despite CHS's Denials

420. On April 11, 2011, Tenet filed a lawsuit, alleging that CHS had been "systematically overbill[ing] Medicare and likely other payors as well…by causing patients to be admitted to its hospitals unnecessarily when, under standard clinical practice, these patients should have been treated in outpatient observation status." Tenet asserted that CHS's improper admissions practices, which the hospital had discovered as "a result of due diligence [] conducted while evaluating" CHS's proposal to acquire Tenet, "overstated CHS's admissions statistics and trends, revenues, profits, and cash flow, and has created substantial undisclosed liabilities to Federal and State healthcare programs, private health insurers and patients."

421. On April 11, 2011, CHS stock suffered a precipitous, statistically significant price decline of $14.41 per share, or 35.8%, to a closing price of $25.89. This price decline reflected the market's

reassessment of the value of CHS's operations and its attractiveness as a potential participant in future health care industry consolidation. CHS reported trading volume totaled 44.7 million shares on April 11, 2011. April 11, 2011 was at the time, and remains to this day, the date of the largest price decline and highest trading volume in CHS's history.

422. In its April 11, 2011 press release, CHS asserted "Tenet's allegations are completely without merit and we intend to vigorously defend ourselves…Providing high-quality patient care is the Company's most important priority." CHS also rejected the lawsuit as a "self-serving" tactic to ward off CHS's hostile takeover bid.

423. On the same day, Wells Fargo reported that Cash told Wells Fargo that Blue Book use was discontinued in 25-30 hospitals and CHS "planned to convert the remainder of its hospitals to this system by the end of 2011 without any material negative impact." As a result, Wells Fargo maintained its "outperform" rating on CHS stock. SIG Susquehanna Financial, LLP made the same point in concluding CHS had "solid answers to the allegations raised by THC [Tenet]."

424. Morgan Stanley and Deutsche Bank also expressed confidence in CHS management. On April 13, 2011, Morgan Stanley reported that its "read is that CYH[11] will be able to offer context around its policies that will help near-term sentiment." On April 15, 2011, Deutsche Bank announced it was "increasingly comfortable with CYH's exposure to

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[11] 11 CYH is the stock symbol for CHS.

THC's allegations," believing that CHS's stock value would rebound "once the market becomes more informed about CYH's exposure to THC's allegations."

425. In an April 18, 2011 press release, Smith reiterated CHS's position that the Tenet litigation was "irresponsible and inaccurate." He also stated "[w]e are confident that our business practices are appropriate. CHS also amended its previous offer to acquire Tenet in an all-cash offer at $6 per share.

426. CHS's efforts at influencing analysts' sentiment was successful with its stock price partially rebounding from a closing price of $25.89 on April 11, 2011, to a closing price of $31.38 on April 12, 2011. CHS stock continued to generally trade within a $29 to $33 per share price range from April 13, 2011 through May 9, 2011. However, after CHS withdrew its bid to acquire Tenet on May 9, 2011, its common stock began to trade at prices almost exclusively below $30 per share, below its $31.90 price level immediately before the Company's December 9, 2010 public announcement of its offer to acquire Tenet. CHS's stock price continued to fall further over the next months, closing at $20.28 per share immediately before the Company announced its 3Q 2011 earnings on October 26, 2011.

427. On April 22, 2011, Tenet announced that the Board of Directors had again unanimously rejected CHS's offer. Tenet explained that, in addition to finding that the offer still grossly undervalued Tenet, it "could not ignore the concerns regarding disclosure and regulatory compliance that we raised in the lawsuit filed against Community Health on April 11." The release stated that

"[a]lthough [CHS] characterized our claims as 'baseless'…[CHS] subsequently disclosed that [the OIG] issued a subpoena…and that this subpoena was similar in scope to one previously issued by the Attorney General of the State of Texas in November 2010."

428. On April 22, 2011, after receiving Tenet's rejection, CHS issued a press release expressing disappointment in Tenet's decision and characterizing the Tenet lawsuit as "irresponsible."

429. The statements in ¶¶ 422, 425, 428 were false and misleading. As described herein, CHS knew that the Blue Book and the Company's "no observation" policy were used to improperly admit patients who would have been placed in less-profitable observation using InterQual. Further, CHS was also well aware that the tools the Company used to boost its admissions numbers, including the Blue Book, Pro-MED, admissions benchmarks and physician incentives, put CHS at risk for substantial non-compliance with Medicare, which could subject the Company to government investigations and fines. It also raised questions whether CHS's financial pressure on physicians or hospital staff conflicted with its stated "quality of care" priority. In fact, Defendants knew that CHS's admissions practices were the subject of numerous governmental investigations, which resulted in a substantial payment to the DOJ to settle those claims.

First Quarter 2011

430. On April 27, 2011, after the close of business, CHS issued financial results for the first quarter ending March 31, 2011 (the "1Q 2011

Release"). In the release, CHS disclosed that although total admissions increased 1.4% from 1Q 2010, same-store admissions decreased by 1.4% from the prior year period.

431. On April 28, 2011, the Company filed its Form 10-Q, which was signed by CEO Smith and CFO Cash (the "1Q 2011 Form 10-Q"). In the 1Q 2011 Form 10-Q, the Company attributed the decrease in same-store admissions to a decrease in admissions from lower birthrates "driven by the downturn in the economy, reductions in one day stays of which over 75% related to non-Medicare patients, [and] reductions due to weather and service closings."

432. That same day, CHS also held its 1Q 2011 earnings call, during which the Company provided an 112-slide PowerPoint presentation titled "CHS Response Presentation" (later filed with the SEC as an attachment to a Form 8-K), which refuted the allegations made against the Company by Tenet.

433. In the earnings call, Smith suggested that the shift in revenue from inpatient to outpatient was due, in part, on the "unintended result of the economy over the last number of years," which was a high level of unemployment (the implication being that in times of high unemployment, prospective patients postpone and defer procedures). Smith explained that when "more people get employed or go back to work, then the commercial enrollment will go up, which will drive the commercial admissions."

434. Smith's focus on the economy as driving admissions was materially misleading and incomplete in failing to account for the effect on

admission due to CHS hospitals' change in admissions criteria. As Cash long made clear to CHS's Management Committee, "82% of admissions are not related to economy."

435. On the same call, Cash addressed Pro-MED, representing that "[t]his system does not order tests. This system does not make any recommendation to physicians to admit patients, place patients in observation, or discharge patients." However, Cash falsely minimized Pro-MED's functions by characterizing it as exclusively a tracking system in the ED. On the contrary, Pro-MED was used to influence physician decision-making by systematically ordering patient tests through test-mapping.

436. During the call, Lynn T. Simon ("Simon"), CHS's SVP and Chief Quality Officer, denied that CHS offered incentive payments to emergency department physicians to admit higher numbers of patients, stating "CHS maintains strong controls regarding physician contracts, and we do not believe that there have been any bonus payments to physicians related to ER admissions." CHS had previously made this same misleading claim to analysts after news of the *Tenet litigation* broke.

437. However, CHS failed to disclose that it provided monetary incentives at all levels of its hospitals to systematically boost ED admission rates. For example, in 2009, two emergency department staff members of Alta Vista Hospital sent CHS management letters in which, although written separately and at different times, they both reported that emergency department physicians were receiving bonuses – called a "risk pool" – for "the

number of people that they see and admit." "The more [admissions] they get, the more the bonus." In January 2010, Cherokee Medical Center told Division President Miller: "I feel very good about the incentive plan we have put in place for our ER physicians…and it seems to be having a positive effect."

438. In its presentation, CHS repeated many of the same assertions it had made since its initial April 11, 2011 denial of Tenet's allegations, including:

(a) "Tenet's lawsuit has no merit…and no material impact on CHS operations going forward."

(b) "We believe that Tenet is wrong in claiming CHS forced observations into inappropriate admissions at Triad."

(c) "Pro-MED does not order tests."

(d) "[N]o statistical correlation exists between outpatient observation visits and inpatient admission at CHS hospitals."

(e) Tenet makes a faulty inference that "all observation cases are inappropriate admission [which] ignores patients treated and released from ER."

(f) "CHS emergency room admission rate is in line with peer group."

439. The foregoing representations in items (a)-(c) were materially false and misleading for the reasons set forth in ¶¶ 15-20, 370, 464, 466.

440. CHS's claim that there was no "statistical" correlation between outpatient observation visits and inpatient admissions was materially misleading and incomplete in failing to disclose that CHS's practices produced a direct and meaningful correlation between the two. In October 2007, CHS told the CEO at its newly acquired Greenbrier Hospital (a Triad Hospital) that by "using CHS 'Blue Book' criteria…the hospital should experience a significant reduction in Medicare and other outpatient observation status patients and a significant increase in inpatient admission." Lipp made it abundantly clear that "we want to avoid observation as much as possible" and that applying the Blue Book would result in increasing one-day stays and reduce observation numbers.

441. Moreover, the Blue Book's exclusion of observation status produced CHS's desired result. Tenet's expert analysis showed that one year after the acquisition of Triad hospitals, the observation rate dropped 52% while the one-day stay admission rate increased by about 33%. *See* ¶¶ 83, 224, *supra*. Both the large declines in observation rates and increase in the rate of one-day stays were statistically significant.

442. Lead Plaintiff's healthcare data specialist also showed that CHS's 2009 observation rates of 4.89% were substantially below the national average of 12.7% and CHS's peers and that CHS's admission rate was substantially above the national average. In addition, CHS saw a rapid increase in CHS's one-day stays, which is a recognized "red flag" to the government. Nearly 70% of CHS's hospitals were

substantially above the national average for the number of ED admits with one-day stays in 2009.

443. CHS was also wrong in suggesting in its April 2011 presentation that Tenet's analysis of CHS's low observation rate was flawed in failing to consider the simple explanation that a large number of patients, instead of being placed in observation status, are treated in the ED and discharged.

444. To examine this contention, Lead Plaintiff's expert reviewed calculations using three sets of data: (1) CHS's "ED-to-Observation" rate, as the percentage of all patients presenting to EDs who are treated in observation status; (2) "ED-to-Inpatient" rate, as the percentage of all patients visiting EDs who are admitted to a CHS hospital; and (3) CHS's "ED-to-Home/Other" rate, as the percentage of all patients visiting the EDs who are treated in the ED on an outpatient basis and then discharged home. Each of these data sets was adjusted for patient case-mix, teaching status, urban/rural, disproportionate share and size.

445. Under this methodology, CHS's ED-to-Observation rate (2.01%) is approximately 57% below the national average (4.72%). CHS's divergence from the national average is statistically significant, meaning that this difference is extremely unlikely to have been the result of chance.

446. Similarly, the Medicare data shows that CHS has a much higher ED-to-Inpatient rate (40.11%) than the national average (35.76%), and a higher rate than most of its peers. Again, CHS's divergence from the national average is statistically

significant, meaning that this difference is extremely unlikely to have been the result of chance.

447. In contrast, CHS's ED-to-Home/Other rate (57.99%) is virtually the same as (in fact, slightly lower than) the national average and within the same range as its peer hospital operators. Thus, CHS's low observation rate is not explained by a higher than normal ED-to-Home/Other rate.

448. Moreover, the analysis of the Medicare data shows that CHS's low ED-to-Observation rate correlates with its high ED-to-Inpatient rate relative to the industry. In short, CHS did not discharge patients who would have to be observed at other hospitals. Rather, CHS admitted these would-be-observation patients to the hospital, generating significantly more revenues that if these patients had been observed after assessment and stabilization in the ED.

449. Across common patient conditions, such as chest pain, syncope and GI bleeding, CHS's over-admission and under-observation trends are even more persuasive because it makes for a direct comparison for the same medical condition. For each of these conditions, CHS's substantially higher-than-average admissions rate was approximately double (on a percentagepoint basis) CHS's substantially below-average observation rate. Again, CHS's divergence from the national average ED-to observation and ED-to inpatient rates are statistically significant, meaning that those differences are extremely unlikely to have been the result of chance.

450. In sum, these analyses of Medicare data showed that CHS was admitting, and did not send home, ED patients who would be observed at other hospitals.

451. Finally, CHS's representation that "CHS's emergency room admission rate is in line with its peers," (Presentation, p. 36), and the statistical analysis used to support that claim was also materially false and misleading. As determined by Plaintiff's expert, to make CHS's performance fall within industry norms, CHS presented a faulty analysis that misleadingly aggregated all patient conditions.

452. However, it was common industry practice to adjust for patient case mix in order to perform an apples-to-apples comparison among peer hospital systems. Lead Plaintiff's healthcare expert determined that taking case mix differences into account, the data reveals precisely the opposite results than presented by CHS. In fact, the data, as adjusted, shows CHS is a "consistent outlier" with the highest system-wide ER rate for non-specific chest pain for 2009: over 73% of CHS's hospitals had admission rates above the 80th percentile of the national benchmark.[12]

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[12] According to the Short-Term Acute Care Program for Evaluating Payment Patterns Electronic Report ("PEPPER"), which was designed to assist hospitals in monitoring compliance with Medicare guidelines and preventing fraud and abuse, hospitals that are at or above the 80th percentile are outliers that warrant closer scrutiny. TMF Health Quality Institute. 2011. "Short-Term Acute Care Program for Evaluating Payment Patterns Electronic Report User's Guide, 6th Ed." *Program for*

453. Moreover, it is appropriate to adjust system-wide ED admission rates to account for the time it takes new hospitals to implement and enforce the Blue Book. Lead Plaintiff's expert confirms that, when considering 2003-2009 data (within two years of the Triad acquisition) hospitals' one-day stays soared from below the national average to 30% above for all diagnosis groups and 100% above the average for non-specific chest pain.

454. On May 2, 2011, CHS increased its Tenet bid to $7.25 all cash as its best and final offer. CHS stipulated that if Tenet did not begin good faith negotiations by May 9, 2011, "the offer will expire and CHS will withdraw its nominees for election to Tenet's Board of Directors." That afternoon, Cash presented at the Deutsche Bank Annual Healthcare Conference. At the conference, Cash again stated that InterQual was "fairly close to our current Blue Book criteria." Cash also reasserted that Pro-MED "doesn't change to admit or put into observation or anything of that nature. It's simply a tracking system." Cash reiterated his claim concerning Pro-MED at a Merrill Lynch conference on May 11, 2011.

455. The foregoing representations in ¶ 454 were materially false and misleading half-truths. Although modified in 2009 and 2010, the criteria for the Blue Book and InterQual still diverged in many respects. Cash's statement created the false impression that the switch to InterQual did not and would not have any impact on CHS's admissions.

Evaluating Payment Patterns Electronic Report. *available at* http://www.pepperresources.org.

456. Cash also misled investors with respect to Pro-MED because it was used to track compliance with the Blue Book criteria and enforcement of revenue-driving benchmarks. *See*, ¶ 438, *supra*.

457. On May 9, 2011, Tenet issued a press release announcing that it had rejected CHS's final offer. That same day, CHS publicly withdrew its offer.

458. On June 17, 2011, Wells Fargo issued another report supporting CHS's position. Wells Fargo explained that it did not find Tenet's charges convincing based upon CHS's representations in the April 28, 2011 earnings call and presentation, which provided a "detailed illustration" of how the Company's "lower rate of observation did not drive a meaningfully higher than average admission rate for the company."

459. On July 28, 2011, CHS issued a press release announcing its 2Q 2011 operating results (the "2Q 2011 Earnings Release"). CHS reported that while total admissions remained flat from 2Q 2010, same-store admissions decreased 2.5% from the prior year and 1Q 2011.

460. In CHS's 2Q 2011 Form 10-Q filed the same day, and signed by Smith and Cash, the Company attributed the decrease in same-store admissions to a decrease in women's services, fewer flu and respiratory-related admissions, and reduction due to competition and certain service closures. On CHS's 2Q 2011 earnings call, Smith indicated that the economy was driving higher outpatient rates at the cost of inpatient admissions, and that the situation

would remain this way "as long as the economy is in pretty poor shape."

461. While Defendants attempted to portray the shift from inpatient to outpatient as the result of an industry trend due to economic forces, they failed to disclose that the Company was more vulnerable than other healthcare providers to the shift from inpatient admissions to observations, as CHS could not sustain its high level of inpatient admissions once it began removing the Blue Book from its hospitals. CHS claimed that the rise of ED patients put into observation was due to a whole host of environmental, economic and service-related factors. While literally true, Defendants failed to disclose that a central reason was that CHS hospitals were no longer relying on the Blue Book's improper admissions criteria.

462. On August 2, 2011, Deutsche Bank reported that CHS had "confirmed that there was no impact on the day to day operations at any of its hospitals" from the allegations or government investigations, however, CHS misled the analysts in failing to disclose that the hospitals were uniformly seeing a reduction in admissions.

The October Disclosure

463. On October 26, 2011, CHS issued a press release announcing financial results for the third quarter ending September 30, 2011 (the "3Q 2011 Release"). Earnings were modestly lower from 3Q 2010 while same-store admissions decreased 7.0% from the prior year. The Company also filed its Form 10-Q, which was signed by CEO Smith and CFO Cash (the "3Q 2011 Form 10-Q"). The 3Q 2011

Form 10-Q also reported the substantial drop in same-store admissions.

464. During the 3Q 2011 conference call, Cash conceded that the adverse impact of the transition from the Blue Book to InterQual was company-wide – 75% of the hospitals that converted to InterQual had a decline in inpatient admissions. Smith and Cash attributed the 7.0% admissions decline in part to a "[r]eduction in one day medical admissions," stating that "chest pain admissions accounted for 40% of the decline."

465. Cash also admitted that CHS's admissions challenge "will continue into the fourth quarter," while Smith acknowledged that "there's no question we've had some adverse impact related to issues…around the Tenet lawsuit."

466. CHS's reversal of its prior position stunned investors and industry analysts. A J.P. Morgan analyst expressed he was "just a little surprised" to see the steep decline, given that in many rural communities CHS was "the only guy in the market." Kevin Fishbeck of Bank of America remarked that "a 7 percent decline in admissions is just a really big number." The Jeffries Group also observed that CHS "suffered from a sharp decline in admissions."

467. On October 27, 2011, CHS's stock price dropped by $2.32 per share, or 11.4% from its October 26, 2011 closing price of $20.28 per share. This was a statistically significant price decline. October 27, 2011 trading volume of 8.7 million shares was higher than any date during the Class Period with the notable exceptions of (1) the day CHS publicly announced its offer to acquire Tenet

(December 10, 2010); and (2) four days immediately after Tenet publicly announced its allegations against CHS (April 11, 12, 13, and 18, 2011).

468. The decline reflected the market recognition that, contrary to the Company's prior representations that the transition to InterQual would not adversely impact CHS's observations, CHS was clearly unable to maintain its level of inpatient admissions. Moreover, the admissions decline highlighted the divergence between Blue Book admissions practices and InterQual's industry-accepted criteria that underlie the Tenet lawsuit.

469. Recognizing the new reality, analysts were quick to revise their opinion of CHS. On October 28, 2011, Wells Fargo reported that it was downgrading CHS's rating to Market Perform from Outperform. Wells Fargo explained:

> …we had expected CYH's admission practices would see little or no impact from the allegations made by Tenet…this does not appear to be the case. *Same-store inpatient admissions declined by 7% overall and by a greater amount at smaller facilities due to what the company described as negative press it has received because of the allegations by Tenet and subsequent OIG investigation*. Our prior view which was consistent with the company's expectations had been that CYH's admission practices were in line with the industry and therefore would not change significantly. We believe this view was incorrect…CYH's comments about weak admission trends because of the negative press could mean Tenet's claims

> have more validity than originally thought, in our view.
>
> * * *
>
> CYH's acknowledgement that the admission trends were hurt by the negative publicity could make it more likely that the OIG investigation may find some issue with CYH's prior admitting practice, in our view.

470. Similarly, on October 26, 2011, J.P. Morgan remarked that it found "it[] a bit more troubling…to see inpatient volume drops of this size." Further, while CHS offered "reasonable explanations," J.P. Morgan was not convinced, explaining that "the print [explanation] likely does less to satisfy the market's quests for signs of continued stability than 2Q did. The latter factor is mostly about whether the ongoing investigations will be a meaningful hindrance/distraction...[C]ompared to the 2Q, the 3Q is somewhat less persuasive in diffusing that view."

471. RBC Capital Markets reported on October 28, 2011, "CYH shares sold off after 3Q 2011 results failed to impress." RBC Capital Markets also noted that it found CHS's "[f]undamentals were disappointing."

CHS Settles with the DOJ

472. On August 4, 2014, the DOJ announced that CHS agreed to pay $98.15 million to settle multiple whistleblower *qui tam* lawsuits which alleged that CHS "knowingly submitted or caused to be submitted claims for payment to the Government healthcare Programs for certain inpatient admissions…that were medically unnecessary and

should have been billed as outpatient or observation services."

473. Specifically, the United States alleged that from 2005 to 2010, CHS engaged in a deliberate corporate-driven scheme to increase admissions of inpatient beneficiaries over the age of 65 who frequented EDs at 119 CHS hospitals. CHS then improperly submitted claims for repayment to Medicare, Medicaid and the Department of Defense's Tricare program in violation of the False Claims Act.

474. In the DOJ's August 4, 2014 press release, United States Attorney for the Middle District of Tennessee, David Rivera, observed that "[t]his is the largest False Claims Act settlement in the district and it reaffirms this office's commitment to investigate and pursue health care fraud that compromises the integrity of our health care system." Rivera emphasized that his office "is committed to ensuring that all companies billing government healthcare programs are responsible corporate citizens and that hospital providers do not engage in schemes to increase medically unnecessary in-patient admissions of government healthcare program beneficiaries in order to increase profits."

475. In the release, U.S. Attorney Anne M. Tompkins for the Western District of North Carolina echoed these sentiments: "Health care providers should make treatment decisions based on patients' medical needs, not profit margins…We will not allow this type of misconduct to compromise the integrity of our health care system." (Emphasis added).

476. As part of CHS's settlement with the DOJ, CHS also entered into a Corporate Integrity

Agreement ("CIA") with the Department of Health and Human Services – Office of the Inspector General, to create a compliance program that addressed and ensured adherence to the requirements of Medicare and other Federal health care programs. CHS was required under the CIA to engage in significant compliance efforts for the next five years. The CIA also created several new measures that gave the HSS-OIG additional oversight over the Company.

477. As one of the compliance measures, CHS was required to overhaul its policies and procedures to cover, *inter alia*, Federal health care program requirements and CHS's code of conduct. The CIA mandated CHS amend its billing and reimbursement requirements to address (i) the proper and accurate submissions of claims and cost reports to Federal health care programs, (ii) the proper and accurate documentation of medical records, (iii) the proper and accurate assignment and designation of patients into inpatient, outpatient, or observation status, and (iv) the necessary and appropriate length of stays and timely discharges for all patients.

478. Regarding the documentation of medical records, CHS was required to include provisions that would ensure physicians were aware of relevant Federal health care program requirements governing admission and any relevant Medicare regulation regarding treatment of a patient as inpatient. Further, the Company was obligated to inform Case Management employees of the requirements for determining the medical necessity and appropriateness of inpatient admissions, such as applicable Medicare rules and regulations.

479. CHS also agreed to employ an independent review organization to ensure CHS was in compliance with both the CIA and Federal health care program requirements.

480. As explained in the August 4, 2014 release by Inspector General David R. Levinson, "*a rigorous multi-year Corporate Integrity Agreement requiring that the company commit to compliance with the law [will] ensure the company's fraudulent past is not its future*." (Emphasis added).

CLASS ACTION ALLEGATIONS

481. Lead Plaintiff brings this action as a class action pursuant to Federal Rule of Civil Procedure 23(a) and 23(b)(3) on behalf of the Class, which consists of all those who purchased or otherwise acquired CHS common stock during the Class Period and were damaged thereby. Excluded from the Class are Defendants herein, the officers and directors of the Company at all relevant times, members of their immediate families and their legal representatives, heirs, successors or assigns, and any entity in which Defendants have or had a controlling interest.

482. The members of the Class are so numerous that joinder of all members is impracticable. Throughout the Class Period, CHS common stock was actively traded on the NYSE. While the exact number of Class members is unknown to Lead Plaintiff at this time and can be ascertained only through appropriate discovery, Lead Plaintiff believes that there are hundreds or thousands of members in the proposed Class. Members of the Class may be identified from records maintained by CHS or its transfer agent and may be notified of the

pendency of this action by mail, using the form of notice similar to that customarily used in securities class actions.

483. Lead Plaintiff's claims are typical of the claims of the members of the Class as all members of the Class are similarly affected by Defendants' wrongful conduct in violation of federal law that is complained of herein.

484. Lead Plaintiff will fairly and adequately protect the interests of the members of the Class and has retained counsel competent and experienced in class and securities litigation. Lead Plaintiff has no interests antagonistic to or in conflict with those of the Class.

485. Common questions of law and fact exist as to all members of the Class and predominate over any questions solely affecting individual members of the Class. Among the questions of law and fact common to the Class are:

(a) were the federal securities laws violated by Defendants' acts as alleged herein;

(b) were material misrepresentations made by Defendants to the investing public during the Class Period about the business, operations, and management of CHS;

(c) did Defendants act knowingly or recklessly in issuing false and misleading statements;

(d) did Defendants' conduct artificially inflate the prices of CHS common stock during the Class Period;

(e) did the members of the Class sustain damages and if so, what is the proper measure of damages; and

(f) does pre-judgment interest continue to accrue to compensate the Class for the time value of money since the alleged wrongdoing.

486. A class action is superior to all other available methods for the fair and efficient adjudication of this controversy because joinder of all members is impracticable. Furthermore, as the damages suffered by individual Class members may be relatively small, the expense and burden of individual litigation make it impossible for members of the Class to individually redress the wrongs done to them. There will be no difficulty in the management of this action as a class action.

487. Lead Plaintiff will rely, in part, upon the presumption of reliance established by the fraud-on-the-market doctrine in that:

(a) Defendants made public misrepresentations or omitted facts during the Class Period;

(b) the omissions and misrepresentations were material;

(c) CHS common stock traded in efficient markets;

(d) the Company's shares traded with liquidity in moderate to heavy volume during the Class Period;

(e) the Company's common stock traded on the NYSE, and the Company was covered by numerous securities analysts;

(f) the misrepresentations and omissions alleged would tend to induce a reasonable investor to overvalue the Company's common stock; and

(g) Lead Plaintiff and members of the Class purchased and/or sold CHS common stock between the time the Defendants failed to disclose or misrepresented material facts and the time the true facts were disclosed, without knowledge of the omitted or misrepresented facts.

488. The extension of the end Class Period through October 26, 2011, and the claims asserted during that extended period, relate back to the filing of the initial complaint in this consolidated action on May 9, 2011. Lead Plaintiff purchased CHS shares at inflated prices during this extended period. *See* Amended Certifications (appended to this complaint).

489. The claims asserted during this period arise out of the *same course of conduct* challenged in the initial complaints and as further clarified in the Consolidated Complaint filed on July 12, 2012. Dkt. No. 68. Between April 11, 2011 and October 26, 2011, CHS repeatedly publicly denied the allegations set forth in Tenet Complaint and misrepresented the true impact discontinuing the Blue Book would have on CHS financial performance.

490. Defendants were on notice of the facts that support extending the close of the Class Period to October 26, 2011 since these facts were substantially alleged in the Consolidated Complaint. *See e.g.*, Dkt. No. 68, ¶¶ 180-183. The Consolidated Complaint also

alleged in detail how, after Tenet filed its complaint, CHS went to great lengths to deny Tenet's allegations by contacting analysts who followed CHS stock and by preparing a 112-page presentation on April 28, 2011, in an attempt to discredit Tenet and its claims. *Id.* at ¶¶ 28, 33, 195-96, 198-204.

491. Accordingly, pursuant to Fed. R. Civ. P. 15(c)(1)(B), the allegations in this complaint relate back to the filing of the Initial Complaint.

NO SAFE HARBOR

492. CHS's generalized "Safe Harbor" warnings that accompanied its forward-looking statements ("FLS") issued during the Class Period were ineffective to shield those FLS from liability. For example, CHS's warnings in its 2010 Form 10-K that the statements included in the annual report "could differ from actual future results" (p. 31) was generalized boilerplate that was not meaningful and failed to provide substantive information tailored to the known risk that CHS faced; for example, that discontinued use of aggressive admissions practices would have a substantial negative impact on its same store admissions and ED revenues going forward.

493. Moreover, Defendants' risk disclosures were themselves misleading in failing to disclose current facts that (a) undercut the reliability and good faith basis of the FLS, and (b) minimized and concealed the actual heightened risks that the Company faced.

494. Defendants are also liable for any false FLS pleaded because, at the time each FLS was made, Smith or Cash knew the FLS was false and they

authorized and/or approved the FLS knowing that the FLS was false.

495. The historic or present tense statements, including opinion statements relating to the Company's current condition and/or compliance with federal rules and regulations, made by Defendants, were not forward looking.

CLAIMS FOR RELIEF

COUNT I

Against All Defendants for Violations of Section 10(b) and Rule 10b-5 Promulgated Thereunder

496. Lead Plaintiff repeats and realleges each and every allegation contained above as if fully set forth herein.

497. During the Class Period, Defendants engaged in a course of conduct, pursuant to which they knowingly or recklessly engaged in acts, transactions, practices, and courses of business that operated as a fraud and deceit upon Lead Plaintiff and the other members of the Class; and made various untrue statements of material facts and omitted to state material facts necessary in order to make the statements made, in light of the circumstances under which they were made, not misleading in connection with the purchase and sale of common stock. Such practices were intended to, and, throughout the Class Period, did: (a) deceive the investing public, including Lead Plaintiff and other Class members, as alleged herein; (b) artificially inflate and maintain the market price of CHS common stock; and (c) cause Lead Plaintiff and other

members of the Class to purchase CHS common stock at artificially inflated prices. In furtherance of this course of conduct, Defendants, and each of them took the actions set forth herein.

498. Information showing that the Individual Defendants acted knowingly, or with reckless disregard for the truth, is peculiarly within their knowledge and control, because as senior officers and/or directors of CHS, the Individual Defendants had knowledge of the details of CHS's internal affairs and core operations.

499. Lead Plaintiff and the Class have suffered damages in that, in reliance on the integrity of the market, they paid artificially inflated prices for CHS common stock. Lead Plaintiff and the Class would not have purchased CHS common stock at the prices they paid, had they been aware that the market prices were artificially and falsely inflated by Defendants' misleading statements. Lead Plaintiff and the Class have sold CHS stock purchased at inflated prices and suffered damage as a result. The market price of CHS common stock declined sharply upon public disclosure of the facts alleged herein to the injury of Lead Plaintiff and Class members.

500. By reason of the conduct alleged herein, Defendants knowingly or recklessly, directly or indirectly, have violated Section 10(b) of the Exchange Act and SEC Rule 10b-5 promulgated thereunder.

501. As a direct and proximate result of Defendants' wrongful conduct, Lead Plaintiff and the other members of the Class suffered damages in

connection with their respective purchases and sales of the Company's securities during the Class Period.

COUNT II

Against the Individual Defendants for Violations of Section 20(a) of the Exchange Act

502. Lead Plaintiff repeats and realleges each and every allegation contained above as if fully set forth herein.

503. During the Class Period, the Individual Defendants participated in the operation and management of CHS, and conducted and participated, directly and indirectly, in the conduct of CHS's business affairs. Because of their senior positions, they knew the adverse non-public information about CHS's misstatements concerning CHS's improper admission practices and unsustainable operating strategy.

504. As officers and/or directors of a publicly owned company, the Individual Defendants had a duty to disseminate accurate and truthful information with respect to CHS's business practices, financial condition and results of operations, and to correct promptly any public statements issued by CHS that had become materially false or misleading.

505. Because of their positions of control and authority as senior officers, the Individual Defendants were able to, and did, control the contents of the various reports, press releases, and public filings that CHS disseminated in the marketplace during the Class Period, as well as statements made during earnings and securities and healthcare analyst conference calls. Throughout the

Class Period, the Individual Defendants exercised their power and authority to cause CHS to engage in the wrongful acts complained of herein. The Individual Defendants therefore, were "controlling persons" of CHS within the meaning of Section 20(a) of the Exchange Act. In this capacity, they participated in the unlawful conduct alleged which artificially inflated the market price of CHS securities.

506. Each of the Individual Defendants, therefore, acted as a controlling person of CHS. By reason of their senior management positions and/or being directors of CHS, each of the Individual Defendants had the power to direct the actions of, and exercised the same to cause, CHS to engage in the unlawful acts and conduct complained of herein. Each of the Individual Defendants exercised control over the general operations of CHS and possessed the power to control the specific activities which comprise the primary violations about which Lead Plaintiff and the other members of the Class complain.

507. By reason of the above conduct, the Individual Defendants are liable pursuant to Section 20(a) of the Exchange Act for the violations committed by CHS.

PRAYER FOR RELIEF

WHEREFORE, Lead Plaintiff prays for judgment against Defendants as follows:

A. Declaring this action to be a proper class action pursuant to Rule 23 of the Federal Rules of Civil Procedure;

B. Requiring Defendants to pay damages sustained by Lead Plaintiff and the Class by reason of the acts and transactions alleged herein;

C. Awarding Lead Plaintiff and the other members of the Class pre- and post-judgment interest, as well as their reasonable attorneys' fees, experts' fees, and other costs; and

D. Awarding such other equitable and injunctive relief as this Court may deem just and proper.

DEMAND FOR TRIAL BY JURY

Pursuant to Rule 38(b) of the Federal Rules of Civil Procedure, Lead Plaintiff demands trial by jury of all issues that may be so tried.

Dated: October 5, 2015

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