UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF MISSISSIPPI
SOUTHERN DIVISION

UNITED STATES OF AMERICA,
ex. rel. MITCHELL D. MONSOUR and
WALTON STEPHEN VAUGHAN **PLAINTIFFS**

V. **Civil Action No. 1:16-cv-38-HSO-JCG**

PERFORMANCE ACCOUNTS RECEIVABLE, LLC,
PERFORMANCE CAPITAL LEASING, LLC,
WADE WALTERS,
STEPPING STONES HEALTHCARE, LLC,
CLAYTON V. DEARDORFF,
BILLY NERREN MARLOW, JR.,
WAYNE WALTERS,
CAH MANAGEMENT - FRANKLIN SERVICES, LLC,
REVENUE CYCLE MANAGEMENT - FRANKLIN, LLC, and
WATKINS, WARD & STAFFORD PLLC **DEFENDANTS**

FIRST AMENDED COMPLAINT

(Jury Trial Demanded)

This First Amended Complaint is brought on behalf of the United States of America, by Mitchell D. Monsour and Walton Stephen ("Steve") Vaughan as Relators/Plaintiffs, for treble monetary damages, civil penalties, and related further relief, pursuant to the *qui tam* provisions of the False Claims Act, 31 U.S.C. §§ 3729 - 3730 ("FCA"), against each of the entities and persons named as Defendants above.

I. The Parties

1. Plaintiff/Relator Mitchell D. Monsour, an adult resident of Hinds County, Mississippi and a citizen of the United States, earned a Masters Degree in Health Administration from the George Washington University in Washington, D.C., and is a Fellow of the American College of Healthcare Executives. He has served for over four decades as a health care executive and management consultant, including service during more than twenty years as a hospital consultant engaged by numerous large and small hospitals.

2. Plaintiff/Relator Walton Stephen ("Steve") Vaughan, an adult resident of Alabama and a citizen of the United States, has for many years served as an administrator and executive of hospital, nursing home, and other health care entities in numerous states. He previously served as Administrator of the Pearl River County Hospital and Nursing Home located in Poplarville, Mississippi.

3. Beginning in 2006, Plaintiff/Relator Monsour, as a consultant engaged on an hourly basis to consult with the North Sunflower Medical Center as to a variety of health care and financial issues, and later Plaintiff/Relator Steve Vaughan as Administrator of the Pearl River County Hospital, began to uncover the activities by the Defendants described below, and disclosed the substance of those activities to federal health care fraud investigators and officials, including

the Office of the Inspector General ("OIG") of the U. S. Department of Health and Human Services ("HHS"), and contractors engaged by the Center for Medicare and Medicaid Services ("CMS") to receive and investigate evidence of fraud against the Medicare system.

4. The origin and initial subject matter of the Relators' investigation of the conduct by the Defendants took place in Pearl River County, Mississippi, in which many such Defendants had conducted activities of the kind described below, such that venue is lawful within the Southern Division of this District.

5. Defendant Performance Accounts Receivable, LLC (hereafter referred to as "PAR"), is a Mississippi limited liability company, owned and controlled by Defendant Wade Walters, located at 104 Bocage Court, Hattiesburg, Mississippi, and has previously been served with process in this action through service on Wade Walters.

6. Defendant Performance Capital Leasing, LLC, is a Mississippi limited liability company, also owned and controlled by Defendant Wade Walters, also located at 104 Bocage Court, Hattiesburg, Mississippi, and has also been previously served with process herein through service on Wade Walters.

7. Defendant Stepping Stones Healthcare, LLC, is a limited liability company, owned and controlled by Defendant Clayton V. Deardorff, which

maintains a principal place of business at 2075 Winchester Drive, Frisco, Texas, and has previously been served herein through execution by Mr. Deardorff of a Waiver of Process.

8. Defendant Wade Walters, an adult resident of Hattiesburg, Mississippi, owns and controls numerous purported management companies which have entered contracts with hospitals and other health care entities. He has been served with process in Hattiesburg, Mississippi, and is represented by counsel of record herein.

9. Defendant Clayton V. Deardorff, is an adult resident of the State of Texas, who owns, controls and participates in numerous management companies which enter contracts with hospitals and other health care entities, purportedly to manage hospital-based outpatient mental health therapy programs. Deardorff has previously waived personal service of process herein, and is represented by counsel of record herein.

10. Defendant Billy Nerren Marlow, Jr., is an adult resident of Sunflower County, Mississippi, and may be served with process at his business address at the North Sunflower Medical Center, 840 North Oak Avenue, Ruleville, Mississippi.

11. Defendant Wayne Walters, is an adult resident of Hattiesburg, Mississippi, and may be served with process at his address of 56 Canebrake

Boulevard, in Hattiesburg.

12. Defendants CAH Management - Franklin Services LLC, and also Defendant Revenue Cycle Management - Franklin LLC, are both limited liability companies organized under the laws of Mississippi, of which the owner and managing member is Defendant Wayne Walters. Both may be served with process herein through service on Wayne Walters at the regular business address of both such companies, of 19 Crane Park, Hattiesburg, Mississippi (or through service on Wayne Walters at 56 Canebrake Blvd., Hattiesburg, Mississippi).

13. Defendant Watkins, Ward & Stafford, PLLC, is a Mississippi Limited Liability Company, and may be served through its Registered Agent, James L. Stafford, at his business address of 213 Commerce Street, West Point, Mississippi.

II. The False Claims Act

14. The False Claims Act (FCA), as amended in 2010, provides in pertinent part, through 31 U.S.C. § 3729(a)(1), that:

> (A)ny person who (A) knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval; (B) knowingly makes, uses, or causes to be made or used, a false record or statement material to a false or fraudulent claim; (C) conspires to do any of the other things recited herein,. . . or (G) knowingly makes, uses, or causes to be made or used, a false record or

> statement material to an obligation to pay or transmit money or property to the Government, or knowingly conceals or knowingly and improperly avoids or decreases an obligation to pay . . . the Government,
>
> * * *
>
> is liable to the United States Government for a civil penalty of not less than $5,500 and not more than $11,000, plus 3 times the amount of damages which the Government sustains because of the act of that person....

15. For the purpose of that provision, the terms "knowing" and "knowingly" mean that a person with respect to information (1) has actual knowledge of the information; (2) acts in deliberate ignorance of the truth or falsity of the information; or (3) acts in reckless disregard of the truth or falsity of the information. No proof of specific intent to defraud is required to establish liability under the FCA. 31 U.S.C. § 3729(b)(1)(A).

III. Hospitals' Entitlements to Medicare Payments

16. The United States, through HHS and CMS as its component agency, administers the Medicare Part A and Medicare Part B programs. Generally, hospitals are reimbursed for inpatient services through the Medicare Part A program, and for outpatient services through the Medicare Part B program.

17. Hospitals, including the rural hospitals on behalf of which the false claims involved in this case were caused by the Defendants to be submitted to

Medicare, are required in order to participate in the Medicare program to enter into contracts (or "Medicare Enrollment Applications") with CMS, in a contract form known as a "CMS-855A" form.

18. Each of the rural hospitals involved in the allegations which follow therefore executed an Enrollment Application and Agreement with CMS in which each such hospital represented that through its authorized responsible official it "understand(s) that payment of a claim by Medicare is conditioned upon the claim and the underlying transaction complying with (Medicare) laws, regulations, and program instructions . . . and on the provider's compliance with all applicable conditions of participation in Medicare."

IV. Critical Access Hospitals' Entitlements to Medicare Payments

19. The Medicare program designates approximately 1,200 to 1,400 small hospitals in the United States as "Critical Access Hospitals" (sometimes referred to as "CAHs"). CAHs are limited to a maximum of 25 beds, and operate in rural and generally economically deprived and medically underserved areas of the United States.

20. Unlike traditional hospital facilities that are paid under Prospective Payment Systems (through which Medicare reimbursement is fixed and capped), Medicare pays CAHs based on each CAH hospital's reported and allowable costs.

Each CAH is entitled, generally, to receive 101 percent (101%) of its allowable costs for outpatient, inpatient, laboratory and therapy services, as well as post-acute care delivered via the CAH's "swing beds". Medicare pays for the same services from CAHs as from other acute care hospitals, but CAHs' payments are not based on the types of service provided or the number of services provided. Payments for CAHs are based on the allowable and reasonable costs they accurately claim to incur, and on the share of costs allocated to Medicare patients as distinguished from non-Medicare patients. Stated simply, the more costs claimed by CAHs on their Medicare cost reports, the more Medicare money they receive.

21. CAHs report their historic costs to Medicare on Medicare Cost Reports, using a CMS Form 2552-96, which contain in Part 1 a certification that sets forth the following: "MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, IF SERVICES IDENTIFIED IN THIS REPORT WERE PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OR INDIRECTLY OF A KICKBACK OR WERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY

RESULT."

22. Medicare cost reports submitted by CAHs contain an additional certification entitled "Certification by Officer or Administrator of Provider(s)" which reads as follows: "I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by [name of facility, ID number of facility] for the cost reporting period beginning [date] and ending [date] and that to the best of my knowledge and belief, it is a true, correct and complete statement prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of the health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations." This language is followed by the signature of the facility's officer, that officer's title and the date on which the cost report is submitted. Exhibit 1 hereto reflects such a certification signed on behalf of Franklin County Memorial Hospital.

23. Medicare generally pays CAHs 101% of inpatient costs, outpatient costs, laboratory costs, therapy services, and post-acute care in swing-beds. Inpatient costs in particular are paid by Medicare on the basis of an average

reported cost per day (called a "per diem" payment).

24. Because CAHs are paid 101% of costs, Medicare payments can increase as CAHs report higher costs or expenses on their cost reports, even if the number of Medicare-eligible patients served, or the extent or quality of health care provided, do not increase. Medicare does not set any particular monetary ceiling on CAH costs.

25. Medicare's payment contractors necessarily presume the accuracy of costs reported by CAHs on their cost reports, and presume that they are all legally allowable, in order to set daily reimbursement rates for inpatient and swing bed services delivered during the year after the costs were incurred and paid.

26. Costs thereby incurred and reported in one year are used by Medicare contractors to set the daily reimbursement rates for a later year's actual per-patient, "per diem" claims by the CAH Hospital. Payments in 2009 by the CAH Hospitals to providers of services to the hospitals identified below, for instance, would not affect any such Hospital's daily reimbursement rates until claims were made in a later year for hospital services delivered to Medicare patients in later year. Because no violation of the False Claims Act of the kinds alleged in this case can occur (and no cause of action for any such violation can arise) until a claim for payment is made to Medicare arising out of substantially earlier illegal transactions and

payments of unallowable costs, a claim made in one month can first give rise to FCA liability on or after that month, though the amount and illegality of the claim resulted from transactions or costs which occurred years earlier.

27. Because Medicare payment contractors rely on the presumed truthfulness of the information disclosed in a CAH's Medicare cost report in determining the amount of reimbursement to be paid to that CAH, that information and that presumed truthfulness are therefore material to, have a natural tendency to affect, and are conditions of entitlement to be paid for, any claim by any CAH for any Medicare payment (and any consideration by Medicare of any such claim).

28. All of the small, rural Mississippi hospitals mentioned below as having been involved in, and whose "costs" were manipulated and swollen by, the Defendants' schemes, were at all relevant times Critical Access Hospitals.

V. The Anti-Kickback Act

29. As a further part of enrolling and re-enrolling in the Medicare system, each such hospital expressly certified, above a signature by its authorized management and on a CMS Form 855-A, that the hospital's administration then had an actual understanding "that payment of a claim by Medicare is conditioned upon the claim and the underlying transaction complying with (Medicare) laws, regulations, and program instructions," expressly "including" the "Federal anti-

kickback statute" among other federal health care laws.

30. Each such hospital therefore had actual knowledge, prior to any claim of the kind alleged to be legally false in this case, that its entitlement to be paid under any such program any amount for any claim was conditioned on that claim not being the result of, and not arising from, any activity undertaken in exchange for any inducement paid or offered in violation of the Anti-Kickback Act ("AKA"), codified at 42 U.S.C. § 1320a-7b(b), which provides as follows:

> Illegal remunerations:
>
> > (1) whoever knowingly and willfully solicits or receives any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind–
> > (A) in return for referring an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under a Federal health care program, or
> > (***B) in return for purchasing, leasing, ordering, or arranging for or recommending purchasing, leasing, or ordering any good, facility, service, or item for which payment may be made in whole or in part under a Federal health care program,***
>
> shall be guilty of a felony and upon conviction thereof, shall be fined no more than $25,000 or imprisoned for not more than five years, or both.
>
> > (2) whoever knowingly and willfully offers or pays any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind, to any person to induce such person –
> > (A) to refer an individual to a person for the furnishing or arranging for the furnishing of any item or service for

> which payment may be made in whole or in part under a Federal health care program, or
> ***(B) to purchase, lease, order, or arrange for or recommend purchasing, leasing or ordering any good, facility, service, or item for which payment may be made in whole or in part under a Federal Health care program,***
>
> shall be guilty of a felony and upon conviction thereof, shall be fined no more than $25,000 or imprisoned for not more than five years, or both.

31. While some "personal services" or "management" contracts with health care providers are effectively exempted from the AKA's reach by a regulatory "safe harbor," 42 C.F.R. § 1001.952(d), one of the express prerequisites for any such "safe harbor" sanctuary is that all of the "aggregate compensation" paid to the management or personal services provider "over the term of the agreement is set in advance" and in writing, and "is consistent with fair market value in arms-length transactions and ***is not determined in a manner that takes into account the volume or value of any referrals or business otherwise generated between the parties***" for which payment may ultimately be made by Medicare. *Ibid.* (Emphasis added).

32. The federal AKA arose out of congressional concern that financial inducements to those who can influence healthcare decisions would result in goods and services being provided that are medically unnecessary, of poor quality, or even harmful to a vulnerable patient population. To protect the integrity of the

Medicare program from these difficult-to-detect harms, Congress enacted a *per se* prohibition against the payment of kickbacks in any form. First enacted in 1972, Congress strengthened the statute in 1977 and 1987 to widen the scope of what constitutes an illegal remuneration under the AKA. *See* Social Security Amendments of 1972, Pub. L. No. 92-603, §§ 242 subparts b and c; 42 U.S.C. § 1320a-7b, Medicare-Medicaid Antifraud and Antiabuse Amendments, Pub. L. No. 95-142; Medicare and Medicaid Patient and Program Protection Act of 1987, Pub. L. No. 100-93.

33. One of the purposes of the AKA is to ensure that health care providers compete for business based on the quality and efficiency of care provided to patients. When important health care decisions are influenced by improper inducements, competition among health care providers is diminished, and charges to federal insurers and other insurers increase accordingly. Consequently, patient care suffers, as an incentive is created for health care providers to distinguish themselves based on the financial inducements they offer rather than on the quality and efficiency of services they provide.

34. The broad scope and substantial penalties provided for in the AKA reflect the significance of the prohibition against kickbacks as a critical tool in the fight against health care fraud and unnecessarily excessive spending on federal

health care programs. *See* H. Rep. 95-393, 95th Cong., 1st Sess. at 44, *reprinted in* 1977 U.S.C.A.N. 3039, 3047.

35. Indeed, as part of the comprehensive health care reform legislation enacted in 2010, Congress amended the AKA to emphasize that "a claim that includes items or services resulting from a violation of this section, constitutes a false or fraudulent claim for purposes of [the False Claims Act]." Patient Protection and Affordable Care Act of 2010 (PPACA), Pub. L. No. 111-148, § 6402(f), 124 Stat. 119 (codified at 42 U.S.C. § 1320a-7b(g)).

VI. Only Costs Necessary, Proper, Reasonable and Related to the Care of Medicare Beneficiaries Are Allowable as Costs Lawfully Included on a Medicare Cost Report

36. Medicare has by federal regulation established rules and guidelines for the reporting of costs by CAHs and other providers who submit their costs through Medicare cost reports. See, e.g., 42 C.F.R. § 413.9.

37. To be properly and lawfully reimbursable by Medicare, costs reported on Medicare cost reports must be directly related to patient care. *Ibid.*

38. Compensation by Medicare for any services provided by a Critical Access Hospital or its ancillary services providers is allowable as a proper Medicare cost only to the extent the services are actually performed in a necessary

function directly related to patient care and only to the extent that the compensation is in an amount that would ordinarily be paid for comparable services by comparable institutions. *Ibid.*

VII. Restrictions on "Allowable Costs" Resulting from Fee Payments to any "Related Party"

39. A hospital seeking reimbursement for costs through a Medicare cost report must disclose on its cost report the identity of any related parties with which it has done business. 42 U.S.C. § 413.17. A provider of services to a hospital is a "related party" (or "related organization") of the hospital whenever the service provider "has the power, directly or indirectly, ***significantly to influence or direct the actions or policies of***" the hospital. *Ibid*. (Emphasis added.) If the service provider is treated as having the commercial or policy-making power significantly to influence or direct the actions or policies of the hospital, the service provider is regarded by the relevant Medicare laws as having "control" over the hospital, and for that reason is a "related party." *Ibid.* As Medicare guidelines have explained, "(t)he term 'control' includes any kind of control, whether or not it is legally enforceable and however it is exercisable or exercised. It is the reality of the control which is decisive, not its form or the mode of its exercise."

40. When a hospital incurs costs as a result of its dealings with a related party, Medicare does not pay the hospital the full amount charged by the related

entity. Such charges by a related party are not "allowable costs." A Medicare provider reporting costs on its Medicare cost reports resulting from payments to any related party is instead permitted to report as "allowable costs" ***only the amount it actually cost the related party to provide the service*****,** not the amount charged by the related party under its contract or otherwise. 42 C.F.R. § 413.17. (Emphasis added.) Medicare guidelines have further explained that a purpose of restrictions on a health care provider's costs in the provider's payments to any related party or organization is "to avoid payment of artificially inflated costs which may be generated from less than arm's-length bargaining."

VIII. Defendants' Schemes to Obtain Fees from CAH Hospitals Contingent on, and as a Fraction of, the Hospitals' Revenues

41. Defendant Wade Walters by early 2007 was actively marketing himself, exclusively to cost-reimbursed CAH hospitals located in rural Mississippi, as a provider of "revenue cycle management," a "service" which he expressly defined as follows:

- Ensure pricing structure is set to maximum reimbursement;
- Assist in implementing new service(s) that help increase cost based reimbursement and recovery and aid in development of referral sources;
- Develop a Strategic Plan for Hospital and implement plan that will increase net revenue by 100 percent in hospital;

- Ensure revenue is recorded correctly to maximize reimbursement;
- Ensure Cost Report is filed correctly and ensure we maximize reimbursement;
- Implement patient friendly billing system with proven collection cycle that will bring AR days in line with industry average; and
- Ensure we are capturing and bill(ing) Physician (fees) correctly.

42. In explicitly defining through such terms what he meant by his "revenue cycle management services" for CAH hospitals, and in thereby seeking remuneration for himself from the hospitals in exchange for making his recommendations and arrangements for additional services or facilities with an explicit goal of maximizing Medicare reimbursements through Medicare's cost-based reimbursement system, Wade Walters (and his CAH hospital clients) entered arrangements which knowingly and willfully violated the AKA.

43. In his design and definition of "revenue cycle management services," Wade Walters (and his CAH hospital clients) also made clear that such services were not themselves directly related to, or necessary to, the actual delivery of medical care to Medicare patients. For that reason, payments for such services were unallowable as costs lawfully to be included on any Medicare cost report by virtue of 42 C.F.R. § 413.9. Wade Walters indeed never received any educational training, and has never been licensed, as a provider of health care of any kind to

anyone. Nor did he ever reside in, or work full-time in, any of the communities in which the rural CAH Mississippi hospitals involved in this case were located.

44. Defendant Wade Walters initially was content with being paid, like other non-employee hospital "consultants," a commercially reasonable (and entirely lawful) hourly rate based on the number of hours he actually worked for a hospital client as itemized by him on monthly invoices. He supplied detailed invoices to his first such CAH hospital client, North Sunflower Medical Center ("North Sunflower"), located in Ruleville, Mississippi, beginning in 2005, seeking and obtaining hourly fee compensation for his consulting work, first at a rate of $100 per hour, later at a rate of $135 per hour, and ultimately, as of July of 2012, at a rate of $150 per hour. Throughout those years, Walters was paid by North Sunflower at those hourly rates for all of the time he actually devoted to that client's "revenue cycle" or other "services."

45. But as of 2007, Wade Walters was not content to be paid based only on an hourly compensation in any amount, or based only on his actual work, or based on any commercially reasonable or legally accepted basis.

(A) North Sunflower Medical Center

46. By February 2007, Walters had formed and entirely owned Defendant Performance Accounts Receivable LLC ("PAR"), through which he entered a

"Revenue Cycle Management Services Agreement" with North Sunflower, in which that cost-reimbursed CAH Hospital became obligated "to pay PAR seven percent (7%) of the collected revenue received" from all services to all patients for all "inpatient, outpatient, swing bed and (geriatric psychiatric) services" which resulted in any "claims for dates of service after February 1, 2007, billable to all payors." Walters' PAR entity was acknowledged in that Agreement to be an "independent contractor," and promised in consideration of those payments of seven percent of "collected revenue received" to perform "Business Office Management as well as Revenue Cycle Management Services for Hospital." Defendant Billy Marlow signed that Agreement on behalf of North Sunflower, and approved all payments to PAR arising out of that Agreement.

47. Between October of 2008 and the termination of that fractional-fee contractual relationship between Walters' PAR and North Sunflower in November of 2015, Defendant Billy Marlow as the Chief Executive Officer (or "Executive Director") of North Sunflower approved payments to PAR under that contract of over fifteen million dollars, specifically $15,159,398.52. The amounts of those monthly payments, which in some single months surpassed $250,000.00, are itemized on Exhibit 2 hereto.

48. Consistent with Walters' and thus PAR's "Revenue Cycle Services"

advice about how a cost-based CAH hospital could "maximize reimbursement" from Medicare, all such payments to PAR itself were included as "costs" in North Sunflower's annual Medicare Cost Reports at the end of each year during which they were paid, and began to increase the amounts of North Sunflower's claims to Medicare for "per diem" payments during each fiscal year following the year in which they were included. To that extent, and to the extent of approximately $15 million in additional Medicare payments to North Sunflower, that hospital's fractional fee payments to PAR partially fulfilled Walters' promise to "develop a Strategic Plan for Hospital and implement plan that will increase net revenue by 100 percent to Hospital," as described above.

49. In July of 2012, Defendant Wayne Walters, the brother of Defendant Wade Walters, was installed as "Administrator" of North Sunflower as a result of the influence of both Defendant Marlow and Defendant Wade Walters over North Sunflower's Board of Trustees. Billy Marlow, previously the "Administrator" of North Sunflower, thereafter nominally assumed the title of "Executive Director" of North Sunflower, and retained power to continue to pay PAR and other companies owned by Wade Walters with funds of North Sunflower.

50. As agreed to and recommended by Defendants Billy Marlow and Wayne Walters, the contract entered by North Sunflower making Wayne Walters

"Administrator" of North Sunflower was entered with a "management company" named Jen-Way LLC, owned and controlled entirely by Defendant Wayne Walters, under which North Sunflower became obligated to pay Jen-Way (and thus Wayne Walters) his own management fee, based not on a fixed salary, or on any other measure of the market value of Wayne Walters' actual work for North Sunflower, but based instead on the revenue received by North Sunflower, specifically one-and-one-quarter percent (1.25%) of collections from the activities of the North Sunflower hospital, and its Rural Health Clinic, and its Wellness Center, further incentivizing the Hospital's administration to increase costs chargeable to Medicare in order to increase collections from Medicare as an end in itself.

51. Throughout his tenure as Administrator and Chief Executive Officer of North Sunflower, from July of 2012 through June of 2015, Defendant Wayne Walters knowingly agreed to the continuance of North Sunflower's agreements with and payments to his brother, Defendant Wade Walters, and thereby agreed to all of North Sunflower's transactions with Wade Walters during that three-year period, including North Sunflower's deference to Wade Walters as a principal decision-maker for North Sunflower in financial, contracting, and cost report matters.

52. In August of 2012, Defendant Marlow caused the North Sunflower

Board to continue to authorize him to pay PAR seven percent of the hospital's "collected revenues" by falsely representing to that Board that PAR had been (and was) performing the "same service" earlier performed by a hospital billing and collections company named Perot Company. Though Perot had charged a percentage only of collections received as a direct result of its own collections activities, PAR's contract in contrast entitled PAR to be paid seven percent of all revenue received from all services to all patients at North Sunflower (regardless of whether or not PAR had contributed to any "collection" of any such revenue or had performed any other work). Though Perot and other hospital billing companies only engaged in billing and collection activities, PAR's "Revenue Cycle Management" contract, in contrast, explicitly required arranging for and recommending the acquisition of additional services and facilities in order to "maximize reimbursement" from Medicare dollars, and was therefore presumptively prohibited (unlike mere "collection" or "billing" contracts) by the Anti-Kickback Act as described above. Defendant Wayne Walters agreed for Marlow to make such misrepresentations to the Board of North Sunflower, knowing that they were false.

53. In September of 2014, the North Sunflower Board renewed Defendant PAR's "Revenue Cycle Management" contract, but revised the percentage of all

"collected revenues" to be paid to PAR from seven percent to five percent.

54. As a part of Defendant PAR's "Revenue Cycle Management Services" to North Sunflower, Wade Walters exercised significant influence and power over which costs were included in the line items or categories of each Medicare cost report filed on behalf of North Sunflower for the years 2010 through 2015. Defendant Billy Marlow, and Defendant Watkins, Ward and Stafford, all deferred to decisions made or directed by Wade Walters in the course of the preparation of each such Medicare cost report on behalf of North Sunflower by Watkins Ward & Stafford.

55. As a result of that influence by Wade Walters, and the acquiescence in that influence and direction by Defendant Watkins Ward & Stafford, over fifteen million dollars ($15,000,000) in costs incurred by North Sunflower in order to pay PAR under its "Revenue Cycle Management Services" contract were falsely represented to be allowable costs in cost reports prepared by Watkins Ward & Stafford, signed by Defendant Marlow or Defendant Wayne Walters, and presented to Medicare through its payment contractors.

56. The Defendants' inclusion of those payments and costs in North Sunflower cost reports for those years caused Medicare to pay to North Sunflower approximately $10,020,292.00 in "per diem" Medicare claims presented after

March of 2010, after the costs were adjusted to reflect the large fraction of North Sunflower costs attributable to the large fraction of Medicare patients it served.

(B) Franklin County Memorial Hospital

57. Beginning in early 2009, Wade Walters set out to collect for himself, through companies he established and entirely owned and controlled for that purpose, fully ten percent (10%) of the revenue collected ("net" only of "refunds" the Hospital was obligated to return to patients) by another cost-reimbursed CAH Hospital, namely the Franklin County Memorial Hospital in Meadville, Mississippi ("Franklin County").

58. In May of 2009, Wade Walters was given contractual power by the Board of Trustees of Franklin County to hire and fire the Hospital's Administrator (and to decide how much that Administrator would be paid), as part of a "Management and Consulting Services Agreement" entered by Franklin County with a new entity named "Performance Management Group, LLC" ("PMG"), owned and controlled entirely by Wade Walters.

59. Under that "Agreement," Walters' PMG entity became entitled to be paid four percent (4%) of all of the Hospital's revenue (after "refunds" paid by the Hospital were deducted) from "all patient and non-patient services" of the Hospital.

60. Also in May of 2009, Wade Walters formed, owned and controlled a new entity he named Franklin Revenue Management LLC ("FRM"), and caused Franklin County's Board also to enter yet another contract entitling Wade Walters (through that entity) to receive yet another and additional fraction of all of that Hospital's revenue. The second fractional-fee contract was titled "Business Office Management and Consulting Agreement," and entitled Walters' FRM entity to receive an additional six percent (6%) of all of that Hospital's revenues from all patient and non-patient activities (net, again, only of "refund" amounts paid).

61. On April 29, 2009, days before he entered with Franklin County both such fractional-fee "revenue cycle" and "management" agreements, Wade Walters by email was given actual notice, by an attorney qualified to render such an opinion as to such health care regulatory matters, that "(w)ith respect to whether or not (those then-proposed) agreements comply with (the) federal anti-kickback law," both such proposed agreements with Franklin County failed to qualify as lawful under any "safe harbor to the Anti-Kickback Statute," for two separate reasons also disclosed to Walters. The first such reason was that "the aggregate compensation under the agreements is not set in advance," as the attorney expressly advised. The second such reason was that neither the contract terms, nor any evidence which Wade Walters had been able to provide to the attorney, qualified as any evidence

that any such fractional-fee compensation terms "represent the actual fair market value for the services provided by (Walters-owned) PMG in an arms length transaction." Though Walters had presented to the attorney the principal fractional-fee contract he had entered with North Sunflower (as described above), the attorney correctly advised Walters that no such North Sunflower agreement provided sound evidence of the reasonableness in the marketplace for such services of the proposed fractional fee arrangement with Franklin County. Walters then proceeded to demonstrate that he could not have cared less about the AKA, as he willfully ignored such legal advice in proceeding, days later, to enter with Franklin County the two different fractional-fee contracts described above.

62. In May of 2012, Wade Walters caused the Franklin County Board to enter two new fractional-fee contracts with yet another Walters-owned entity named "Prime Care Management Group LLC" ("PCM Group"), entitling Wade Walters through that entity to be paid three percent (rather than the previous four percent) of collections from "all patient and non-patient services" of the Hospital in return for Walters' entity having the power to name the Hospital's Administrator and thus control the Hospital's management, and an additional six percent (6%) for continuing to perform his so-called "revenue cycle management services" for Franklin County.

63. Between Franklin County's Fiscal Year 2010 and its Fiscal Year 2016, Franklin County paid the aforementioned Walters-owned entities amounts totaling $2,978,534 under its 4% (later 3%) fractional fee contract with PMG (later, "PCM Group").

64. Also between Franklin County's Fiscal Year 2010 and Fiscal Year 2016, Franklin County also and separately paid Walters-owned Franklin Revenue Management LLC (later, "PCM Group") additional amounts totaling $4,201,871 under its separate 6% fractional-fee contract.

65. Yielding to what its relevant cost report accountants knew to be Wade Walters' significant influence and power over Franklin County's management, and in particular Wade Walters' power to direct the allocation of costs (as purportedly "allowable") in Franklin County's Medicare cost reports, Defendant Watkins Ward & Stafford agreed with Walters to include all such non-allowable "costs" to Franklin County, resulting from all such fractional-fee payments to Wade Walters entities, in all of Franklin County's cost reports for all years beginning with Fiscal Year 2010.

66. The inclusion of those costs in those cost reports, when combined with the inclusion of additional fractional payments arising out of "intensive outpatient services" ("IOP") at Franklin County as described below, caused additional "per

diem" claims to and payments by Medicare to Franklin County, after March of 2010, to total approximately $6,893,998 more than Franklin County would have lawfully received if such non-allowable fractional payments to Walters entities had not been illegally included in earlier cost reports.

67. Throughout all of the years during which Wade Walters managed to pocket for himself all of those millions of dollars in fractional fees, the average number of patients served by Franklin County as overnight inpatients (or "acute care" patients) remained a total of only nine persons. That average number of inpatients did not change during Wade Walters' "management" of Franklin County.

68. Since 2015, Defendant Wayne Walters, individually and through his ownership and control of entities owned and controlled entirely by him, including Defendant CAH Management - Franklin Services LLC, and Defendant Revenue Cycle Management - Franklin LLC, has continued from 2015 until the present date similar unlawful fractional-fee contracts and arrangements with Franklin County, costing Medicare substantial additional sums in per-diem payments for such illegal contractual arrangements.

IX. Schemes to Obtain Fractional Fees from IOP Revenue (and to Fund Kickbacks Therefrom)

(A) Franklin County Memorial Hospital

69. For a number of months prior to May of 2009, Defendant Clay Deardorff, through and with Defendant Stepping Stones Healthcare LLC ("Stepping Stones," owned and controlled entirely by Deardorff), had established an outpatient mental therapy service, typically termed an "IOP" program (for "intensive outpatient therapy") for Franklin County. Therapeutic services within that IOP program were rendered at or near Franklin County's hospital facility, and in the name of Franklin County, with all of the costs of that IOP program included as costs of Franklin County on its overall Medicare cost report as a CAH Hospital.

70. As part of its "management" services, Stepping Stones was in charge of recruiting new patients into Franklin County's IOP program, effectively causing new IOP patients to be "referred" to Franklin County for the rendering of services to be provided entirely (or almost entirely) to Medicare patients, thus generating revenue through additional Medicare payments to Franklin County.

71. Prior to May of 2009, Stepping Stones and thus Deardorff were compensated for their management services through payments by Franklin County of a fixed monthly fee (typically of approximately $2,000), and a reimbursement by Franklin County of Stepping Stone's payments of a fixed monthly salary for a treating physician at the IOP program. That contract, involving fixed periodic payments at a rate reflecting the fair market value for such specified management

services, was directly related to the actual cost of managing the provision of patient services, was commercially reasonable, and was otherwise entirely lawful.

72. But in May of 2009, acting under the "management" and "revenue cycle" contracts with Franklin County described above, Wade Walters assumed control of Franklin County's management and thus its "revenue cycle" and costs. Before that month had expired, Walters had instructed Deardorff (and thus Stepping Stones) that in addition to fixed monthly management fees, Stepping Stones was going to start charging Franklin County a large fractional fee, the monthly amounts of which would be linked to growth in revenue from the IOP program, through increases in recruitments and referrals by Stepping Stones to Franklin County of new IOP patients.

73. Deardorff (and thus Stepping Stones) agreed to Wade Walters' directions. During May of 2009, they entered a new IOP contract with Franklin County under which Stepping Stones would be paid, in addition to an increased monthly fixed fee, ten percent (10%) of "gross charges billed" by Franklin County for IOP services to the extent those "gross charges" exceeded $250,000.00. The parties used the term "deferred fee" to refer to such fractional, volume-based fees.

74. Then, also in 2009, Walters demanded, and Deardorff (and thus Stepping Stones) agreed, that if Stepping Stones was to continue to be

compensated for such IOP services at Franklin County, Wade Walters would require Stepping Stones to pay to Wade Walters (through Walters-owned "Wade Walters Consulting, Inc."), fifty percent (50%) of all amounts that Stepping Stones received in fractional ("deferred") fees from Franklin County. That explicit kickback agreement, reduced to writing and signed by Wade Walters in January of 2010, is attached as Exhibit 3 hereto.

75. As Exhibit 3 also reflects, Wade Walters and Stepping Stones added also a written kickback agreement to provide that Stepping Stones was required not only to pay Wade Walters 50% of all fractional fees received from Franklin County, but also to pay Wade Walters 50% of all fractional ("deferred") fees Stepping Stones would receive from establishing and managing at Wade Walters' invitation a new IOP program for and at Pearl River County Hospital in Poplarville, Mississippi, also a CAH Hospital. Defendant Deardorff later attempted to justify the fractional, volume-based fees arranged for him at Pearl River County Hospital by Wade Walters by reminding that Hospital's Administrator, namely Plaintiff/Relator Steve Vaughan, that "all (of) Stepping Stone's fees are cost-based," and that "the hospital receives 101% of these costs."

76. Those written kickback agreements effectively promised, and all resulting payments by Stepping Stones to Wade Walters (through "Wade Walters

Consulting Inc.") delivered, remuneration by Deardorff and Stepping Stones to Wade Walters, as the indirect controller of Franklin County, in return for continuing to recommend and arrange for Stepping Stones to continue to provide such IOP services. Franklin County's payments to Deardorff and Stepping Stones of the fractional ("deferred") fees, half of which Deardorff and Stepping Stones kept after paying half as kickbacks to Wade Walters, amounted to remuneration by Franklin County to Stepping Stones in return for referring and arranging for larger numbers of IOP patients to Franklin County. None of those additional "deferred" payments were in return for additional services benefitting patients. Actual management of the IOP programs continued to be paid for separately through fixed monthly fees to Stepping Stones (albeit at a higher fixed monthly amount than during the pre-Walters arrangements).

77. In each of their written kickback "Letter(s) of Agreement" concerning their 50/50 split of fractional fees from IOP services, Deardorff, Stepping Stones and Wade Walters fraudulently pretended that the 50% kickback to Walters was in consideration of "financial consulting services" by Wade Walters (through his Wade Walters Consulting entity), pertaining to Stepping Stones' IOP agreement. Clay Deardorff and Wade Walters both knew that to be a false pretense. If Walters provided any "financial consultation" or advice to Deardorff and Stepping Stones,

it was along these lines: "I have taken over the management of this (or these) hospital(s), and if you want to get paid here you will add these volume-based fractional fees to your contract(s), recruit and refer more IOP patients to the hospital(s), and give me half of the money." That hardly qualifies as lawfully compensable "financial consultation" to Deardorff. It only told Deardorff what he had to do, and did agree to do, to keep or enlarge his business in Mississippi through Wade Walters. Neither the legitimate marketplace nor the law recognizes a "fair market value" for time spent by a controller of a hospital to shake down the hospital's vendors for a personal share of the hospital's payments. Those shakedowns are, instead, criminal violations of the AKA.

78. After agreeing in 2009 to impose on Franklin County a fractional ("deferred") fee payment obligation contingent on the volume of revenue resulting from referrals by Stepping Stones to Franklin County of more and more IOP patients, Deardorff and Wade Walters periodically altered the fractional fee structure. In May of 2011 Stepping Stones became entitled to be paid 40% of "gross charges billed" for Franklin Couty for IOP services annually over $600,000. In May of 2013 the fractional entitlement became 30% of gross charges annually billed over $600,000. In May of 2016, the fractional entitlement became 20% of gross charges annually between $250,000 and $900,000.

79. Wade Walters used his control over Franklin County's "management" company to cause Franklin County's Board to approve all such fractional fee arrangements, and used his power over his hand-picked Administrator at Franklin County to get himself paid under the same arrangements.

80. Because all IOP services, charges, "costs" and claims for payment by Stepping Stones after it entered its kickback arrangement with Wade Walters in 2009 "resulted from" that kickback arrangement, all IOP-related costs were legally void and not legally allowable as costs to be added to any Medicare cost report by any hospital. 42 U.S.C. § 1320a-7b(g).

81. Yielding again to Wade Walters' direction and power as to what was to be included in Franklin County's cost reports, Defendant Watkins Ward & Stafford falsely and fraudulently included all such IOP management and "deferred" fees as purportedly allowable "costs" in Franklin County's Medicare cost reports for 2010 through 2017, totaling $1,335,090 in payments to Stepping Stones and thus "costs" to Franklin County (apart from payments by Franklin County to reimburse Stepping Stones for its salary payments to a physician performing IOP services).

(B) Tallahatchie General Hospital

82. In 2010, Defendant Billy Marlow formed Sunflower CAH

Management Group, LLC ("Sunflower CAH Management") for the purpose of receiving, on the model earlier demonstrated by Wade Walters, fractional fees from other cost-reimbursed CAH hospitals in rural Mississippi based on the amounts of their revenue. Defendant Wade Walters served as a "consultant" to Sunflower CAH Management.

83. In 2010 or 2011, Sunflower CAH Management, which at that time was owned by Defendant Marlow, entered a fractional-fee "management contract" with Tallahatchie General Hospital ("TGH"), itself a CAH Hospital based in Charleston, Mississippi, under which TGH gave to Sunflower CAH Management the power to select and employ the Administrator charged with running TGH, and thus to control TGH's operations. In return, TGH also became contractually obligated to pay Sunflower CAH Management seven percent (7%) of all of the revenue TGH collected.

84. In March of 2011, Defendants Marlow and Wade Walters used the new power of Sunflower CAH Management over TGH to cause TGH to enter multiple contracts with Wade Walters, initially through the Walters-owned entity Prime Care Management Group LLC, under which that entity would establish, manage, and recruit patients for, a new IOP service at TGH. (Unless one counts as "IOP management experience" Walters' earlier experience at Franklin County in

shaking down Defendant Deardorff for a financial piece of Stepping Stone's revenue, Wade Walters had no actual experience operating any such mental health service, and certainly had no training or license concerning the legitimate diagnosis and treatment of any mental health patient - or any other kind of medical patient.)

85. Apparently unwilling by then to split fractional fees for IOP services with anyone else, Marlow and Wade Walters caused TGH to become obligated not only to pay Walters' entity a fixed $7,000 monthly for IOP management services, but also and separately to pay Walters fractional fees of 10% of "gross charges billed" up to $250,000, 32% of gross charges billed between $250,000 and $600,000, and 28% of gross charges billed at over $600,000 annually for IOP services at TGH.

86. Defendants Billy Marlow and Wade Walters, and Sunflower CAH Management (along with the TGH Administrator it appointed), caused TGH to pay Walters-owned Prime Care Management Group, between (and including) 2011 and 2014, a total of $2,104,137, all of which was falsely included in TGH's cost report as purportedly allowable costs. Those inclusions of those IOP costs, when adjusted to account for (a) the fraction of Medicare patients at TGH (relative to all patients), (b) the amounts of annual cost report "settlements" during those years, and (c) TGH's entitlement as a CAH to reimbursement equal to 101% of allowable

Medicare-related costs, resulted in additional and unlawful "per diem" amounts paid by Medicare to TGH totaling approximately $2,607,811.

X. Effect of Fractional Fee Payments on the Factual and Legal Falsity of the CAH Hospitals' Resulting Per-Diem Claims to Medicare

87. As all of the Defendants knew, none of the fractional fee payments made by each of the subject CAH Hospitals to Defendant Wade Walters (or to any of his companies) or to Defendant Wayne Walters (or to Defendants CAH Management - Franklin Services LLC, or Revenue Cycle Management - Franklin LLC, or to any of his other companies), or to Defendant Clay Deardorff (or Defendant Stepping Stones), were made in order to compensate anyone for the reasonable market value of any activity necessary to or directly related to the provision of health care services to Medicare (or other hospital) patients. Even where services actually performed by such service providers had a market value, those fractional fee payments, tied only to collections or revenue received by the hospitals (as the result predominantly of the efforts of other persons acting under their health care licenses), had no logical, market-based, or legal relationship with the value of any service provided by any of those Defendants.

88. Instead of arising out of a reasonable market valuation of actual services actually rendered and affecting the delivery of health care, the fractional-

fee remunerations paid by the CAH hospitals to Defendants in this case were knowingly and willfully solicited and received by those Defendants as remuneration in return for arranging for or recommending (or ordering) services and expenditures for which they knew (and intended) that cost-based payments would be claimed and received by the CAH hospitals from the Medicare system, in willful violation of the AKA, resulting in all such claims for per-diem payments being legally and factually false claims in violation of the FCA. All of the Defendants knew that compliance with the AKA was itself material to and a prerequisite to the CAH hospitals' entitlement to any such payments from Medicare, such that all payment claims submitted for all per-diem Medicare payments by all of the subject hospitals were known by the Defendants to be legally and factually false claims made in violation of the FCA.

89. All of the Defendants likewise knew that no costs to any such hospital in discharge of any such obligation to pay any such "consultant" or "administrator" any such fractional fees could lawfully or properly be included as "allowable" costs on any such CAH cost report, and that the false inclusion of such costs on the cost reports of the subject CAH hospitals rendered those reports false statements, the presumed truthfulness of which was material to Medicare contractors' calculations of the amounts of future per-diem payments to be made to such hospitals. If no

such unallowable costs had been included on the hospitals' cost reports, then future per-diem reimbursements to the hospitals by Medicare would have been millions of dollars lower in amount, saving the Medicare system those millions of dollars. The inclusion of those costs caused monetary damages to the United States to the extent of those same millions of dollars.

90. Because the Defendants also knew that such costs incurred to pay fractional fees could not lawfully be included in the CAH hospitals' Medicare cost reports if they were not necessary to, and were not expended directly for, the delivery of health care services to patients, or if they were not reasonably incurred and priced for that purpose, and because such Defendants further knew that the accuracy of the cost reports was material to (and a prerequisite to) the hospitals' entitlement to any payments from Medicare, all payment claims submitted for all Medicare payments by all of those hospitals throughout all relevant years were known by the Defendants to be legally and factually false claims made in violation of the FCA, the payments of which by Medicare contractors caused damages to the United States in amounts including the fractional fee payments itemized above. None of those amounts would have been paid with Medicare funds if Medicare contractors and officials had known the facts itemized above.

91. Through the same conduct, all of the Defendants agreed to and did

knowingly cause Administrators of the three subject CAH hospitals falsely to sign cost report certifications identical to the one reflected on Exhibit 1 hereto, falsely representing to Medicare contractors that all of "the services identified in this cost report were provided in compliance with" Medicare laws, including the AKA. Defendants Billy Marlow and Wayne Walters individually signed such cost report certifications on behalf of North Sunflower, knowing them to be false as to the fractional-fee and other transactions described above.

X. Wade Walters' "Significant Influence" Over, and thus "Related Party" Status as to, North Sunflower, Franklin County, and TGH

92. In demonstrating and using his significant influence over financial and management decisions made at the CAH hospitals noted above, Wade Walters caused each such hospital to enter multiple contracts, in addition to the "fractional fee" contracts described above, with entities entirely owned and controlled by Wade Walters. Given Walters' influence at each such CAH, and his rationale of engaging in transactions in order to "maximize reimbursement" from Medicare funds by maximizing costs to be included on Medicare cost reports, the hospitals were not allowed by Wade Walters the benefit of competitive bidding as to such services, and were not otherwise allowed to seek vendors who had legitimate experience in competently providing such services at competitive market rates.

(A) North Sunflower

93. Beginning in January of 2004, and continuing through at least 2013, Defendants Wade Walters, Billy Marlow and Performance Capital Leasing LLC ("PCL"), an entity owned and controlled entirely by Wade Walters, agreed to cause and did cause North Sunflower to enter at least ten different "Lease Agreement(s)" obligating North Sunflower to pay to PCL, and thus to Wade Walters, additional funds in order to "lease" from PCL modular buildings, permanent buildings and lots, medical equipment, and pharmacy equipment. The parties agreed to affirm in each such lease that PCL was "in the business of leasing" such items. No competitive bids were sought for any such leases or items.

94. Beginning in 2006, and continuing through the end of 2015, Defendants Wade Walters and Billy Marlow also agreed to cause, and did cause, North Sunflower to enter at least three different medical "staffing" contracts obligating North Sunflower to pay Delta Staffing, LLC (owned and controlled entirely by Wade Walters) for the use at North Sunflower of nurses serving as "contract employees" of Delta Staffing LLC. Between October of 2008 and the end of December of 2015, North Sunflower as a result of that contract paid Delta Staffing LLC (and thus indirectly its owner and controller, Wade Walters) $12,930,249 (in addition to all other payments to Walters-owned entities as

described above). For supplying registered nurses to work at North Sunflower, North Sunflower became obligated to pay Delta Staffing $38 per hour as of 2006, $39.00 per hour as of 2007, and $42.00 per hour as of 2010.

95. Defendants Billy Marlow and Wayne Walters represented to the North Sunflower Board in September of 2014 that Wade Walters (through PAR) "manages how to charge out / allocate charges" on North Sunflower's cost reports. Indeed, well into 2016, the year when this case was filed under seal, Wade Walters continued to exercise substantial influence over the financial affairs and decision-making of North Sunflower, as evidenced by an August 17, 2016 email to Wade Walters from North Sunflower's then-Administrator, Sam Miller, beginning with "(t)hanks Wade for taking a look at the financials," and inquiring: "(w)hat are your thoughts about strategy for next year?" Back in January of 2014, the same Sam Miller had to ask Walters: "Are the specialty clinics listed on the latest interim cost reports?"

(B) Franklin County Memorial Hospital

96. Beginning in April of 2010, and continuing at least into the year 2018, Wade Walters and Walters-owned entities Performance Management Group LLC and Franklin Revenue Management LLC, caused Franklin County Memorial Hospital, which was being managed and controlled indirectly by Walters through

his hand-picked Administrator at that CAH Hospital, to enter multiple leases with Defendant PCL, obligating Franklin County to pay to PCL (and thus indirectly to Wade Walters) substantial additional sums in lease payments for the "leasing" by Franklin County of modular buildings, hospital beds, medical equipment (including ventilators, respirators, defibrillators, and pulmonary function machines), and vans (used to haul the increasing numbers of IOP recruits and referrals by Stepping Stones to Franklin County for the performance of purported IOP services).

(C) Tallahatchie General Hospital

97. Beginning in 2010, Defendants Billy Marlow and Wade Walters, demonstrating and using their managerial influence and control (through "Sunflower CAH Management" and otherwise) over TGH, caused TGH to enter a contract with Walters-owned Delta Staffing LLC, under which TGH became obligated to pay Walters (through his Delta Staffing LLC entity) to utilize nurses and other health care providers employed as "contract employees" by Delta Staffing. TGH's contract with Delta Staffing LLC was signed on behalf of TGH, as its "Chief Executive Officer," by Defendant Billy Marlow.

98. In April of 2011, Defendants Billy Marlow and Wade Walters, through their substantial influence on TGH by virtue of their control of TGH's "management company" Sunflower CAH Management Group LLC, caused TGH to

become obligated to pay Wade Walters, through his entity Prime Care Management Group LLC (owned and controlled entirely by Walters), purportedly to establish and operate for TGH a "Rehabilitation Services" program in the name of and at TGH, purportedly delivering occupational, physical, and speech pathology rehabilitation services, in consideration of which Walters (through Prime Care Management Group LLC) was paid $10,000 each month for "managing" such a rehabilitation operation (in addition to TGH's obligation to reimburse Prime Care for its expenses in paying a physician actually to deliver services).

99. In 2011, Defendants Marlow and Wade Walters, as further demonstration and use of their influence over TGH and its "managing company," also caused TGH to become obligated to pay Wade Walters (through the Defendant Performance Capital Leasing LLC, owned and controlled entirely by Walters) lease payments in order for TGH to lease from PCL sixteen hospital beds. Though TGH made lease payments of over $180,000 to PCL during a lease period of fewer than five years, TGH valued the entire beds at the end of that period at only $1,000 per bed for the purpose of buying the beds outright from PCL.

(D) Notice to Cost Report Preparers

100. Defendant Watkins Ward & Stafford PLLC ("WWS"), through senior cost report accountants and preparers all of whom worked as full-time principals at

WWS's Eupora, Mississippi office, originally authored all of the answers and all of the data included on all of the cost reports signed and submitted during all of the years relevant herein on behalf of the three primary CAH Hospitals involved in this case, namely North Sunflower, Franklin County and TGH.

101. WWS accountants for the purposes of their cost report preparations knew, or should and would have known if they had not exercised reckless disregard and deliberate ignorance for the material facts in breach of their professional duties of reasonable care in such accounting matters, that Wade Walters, through the companies named above and owned entirely by Wade Walters, was allowed to and did exercise substantial influence over the financial decision-making and policies at each of the three hospitals, including (but not limited to) decisions about the contents of each such hospital's Medicare cost reports.

102. WWS accountants knew, or should and would have known if they had not exercised deliberate ignorance and professional negligence, that Walters acted in effect as the "boss" of WWS accountants in deciding which costs to insert into which category or line item in WWS's preparation of the hospitals' cost reports. On March 7, 2009, WWS accountant Aubrey Holder received from Wade Walters an email about how Walters "was reconciling the GL (general ledger) Medicare Charges to cost report and came across (an) issue." On July 20, 2010, Wade

Walters informed the same Aubrey Holder that Walters "spoke with the (Medicare contractor) auditor on a couple of adjustments on this audit." On March 15, 2011, Walters emailed Holder asking: "Have you finished North Sunflowers (sic) Report yet? When you finalize, can you send me the ECR file again." On March 17, 2011, Holder emailed Wade Walters: "Just a heads up. I just spoke to a Medicare Cost Report Audit Supervisor regarding the 9-30-09 Medicare Cost Report audit." On May 24, 2011, WWS accountant Jerry Gammel emailed Walters that he was forwarding to Walters a draft cost report as a "draft copy for your review." On February 11, 2015, Gammel emailed Wade Walters: "See attached list for information needed to finish the cost report." On February 28, 2017, Walters emailed Gammel under a subject heading "Tallahatchie and North Sunflowers Cost Reports and PS&R": "Jerry, Can you send me a copy of the Draft Cost reports to review for the above?"

103. And yet, when each relevant Medicare cost report for each of the three subject CAH hospitals expressly asked if there was "any related organization" with significant influence over the policies or financial decisions of any of the three hospitals, WWS accountants falsely answered "No" on each such hospital's cost reports, knowingly causing materially false cost reports to be submitted to Medicare intermediaries.

104. All such cost report forms also explicitly required each such hospital (and thus each cost report preparer) to disclose a "statement of costs (to the related organizations) of services from related organizations," and "costs incurred and adjustments required as a result of transactions with related organizations," clearly explaining on the face of the cost report form that such "information is used" by Medicare contractors "in determining that the costs applicable to services, facilities and supplies furnished by organizations related to you by common . . . control represent reasonable costs as determined under Section 1861 of the Social Security Act. If you do not provide all or any of the requested information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement" from the Medicare program.

105. Despite (and in defiance of) those clear warnings by Medicare, on the face of each cost report form, that full and truthful disclosure of any related party (or "related organization") was material to the lawfulness of any claim for Medicare funds based on any such cost report, Defendant WWS affirmatively concealed (1) the substantial influence that Defendants Wade Walters, PAR and PCL maintained over the financial decisions of North Sunflower, (2) the substantial influence that Defendant Billy Marlow, Defendant Wade Walters, and Sunflower CAH Management had over the financial decisions of TGH, and (3) the substantial

influence that Defendants Wade Walters (and his Performance Management Group LLC and Franklin Revenue Management LLC), and Wayne Walters (and his CAH Management - Franklin Services LLC, and Revenue Cycle Management - Franklin LLC), had over the financial decisions of Franklin County. Those acts of concealment by WWS of those related organizations and parties were committed with professional negligence by WWS, and with reckless disregard and deliberate ignorance by WWS, as to the information then readily available to WWS cost report preparers concerning the roles of those persons and entities in the financial operations of, and cost report preparations for, those hospitals.

106. Defendants WWS, Billy Marlow, Wade Walters and PAR agreed, as to all relevant years of cost reports submitted on behalf of North Sunflower, and Defendant Wayne Walters as Administrator agreed with them as to North Sunflower's cost reports for 2012, 2013 and 2014, to submit to Medicare contractor Novitas Solutions, Inc., false Medicare cost reports affirmatively and falsely representing that there were "No" related parties of North Sunflower, knowing that any such false statement was material to Medicare's decisions about relying on such cost reports to calculate future cost-based reimbursements by Medicare to North Sunflower, and knowing that a truthful disclosure of the influence of those Defendants over North Sunflower, and also knowing of the very

limited actual costs incurred by those Defendants in providing any actual services to North Sunflower, would have resulted in the reimbursements to North Sunflower of only those costs by those related parties, rather than the many millions of dollars in fractional fees paid by North Sunflower to those related parties.

107. The same agreement among the same Defendants to make the same material false statements concealing the influence of Wade Walters and Wayne Walters over Franklin County (and Wade Walters and Billy Marlow over TGH) resulted in and caused the submission by those two hospitals, during the relevant years described above, of false cost reports concealing that influence and theeir related party status from Medicare cost report reviewers and auditors.

108. The Defendants' knowing agreement with respect to all such cost reports as to all three such hospitals, and their knowing, affirmative and overt acts in causing such false cost reports to be submitted on behalf of the hospitals to Medicare contractors, caused materially false and fraudulent claims for future Medicare per-diem payments to be presented to Medicare in violation of Subsection 3729(a)(1)(A) of the FCA, caused false records and false statements to be made and used which were material to Medicare's consideration of such future payments in violation of Subsection 3729(a)(1)(B) of the FCA, and constituted a conspiracy to violate those two subsections in further violation of Subsection

3729(a)(1)(C) of the FCA.

COUNT I

Claims By and on Behalf of the United States for Making False Claims (and for Causing False Claims to be Made)

109. Plaintiffs re-allege and incorporate by reference paragraphs 1 through 108 as though fully set forth herein.

110. This is a claim under the False Claims Act, 31 U.S.C. §§ 3729-33, as amended, against each of the Defendants herein.

111. The Plaintiffs/Relators have standing to maintain this claim by virtue of 31 U.S.C. §3730(b).

112. By virtue of the acts described herein, each of the Defendants knowingly engaged in conduct which they knew would cause and did cause the CAH Hospitals described above knowingly to present false or fraudulent cost reports and claims for per-diem payments to and by Medicare, and therefore to officials of the United States Government in violation of 31 U.S.C. § 3729(a)(1)(A).

113. By virtue of the false claims caused to be presented by the Defendants, the United States has suffered actual damages and is entitled to recover three times the amount which it paid in response to such false claims (and therefore the amount by which it is damaged), plus civil money penalties of not less than $5,500 and not

more than $11,000 for each of the false claims caused to be presented, and other monetary relief as appropriate.

COUNT II

Claim By and on Behalf of the United States for Causing False Records or Statements to be Used to Get Paid, and/or Which were Material to, False Claims

114. Plaintiff re-alleges and incorporates by reference paragraphs 1 through 108 as though fully set forth herein.

115. This is a claim on behalf of the United States under the False Claims Act, 31 U.S.C. §§ 3729-33, as amended, against Accretive.

116. The Plaintiffs/Relators have standing to maintain this claim by virtue of 31 U.S.C. §3730(b).

117. By virtue of the acts described above and the Defendants' uses of, or activities causing to be used, false records and statements to get false and fraudulent claims paid and approved by the Government, and otherwise the Defendants' acts causing false records and statements to be used which were material to false or fraudulent claims made by the relevant CAH hospitals, the Defendants knowingly made and used, and caused to be made and used, false cost report representations, and other false records or false statements, which they knew to be material to false or fraudulent claims to Medicare, in violation of 31 U.S.C. §

3729(a)(1)(B), as amended in March of 2010.

118. By virtue of the acts described above and the Defendants' uses of, or activities causing to be used, false records and statements to get false and fraudulent claims paid and approved by the Government, and otherwise all of the Defendants' activities causing false records and statements to be used which were material to false or fraudulent claims, all of the Defendants herein knowingly made and used, or knowingly caused to be made and used, false records and false statements which they knew to be material to false or fraudulent claims to Medicare, in violation of 31 U.S.C. § 3729(a)(1)(B), as amended in March of 2010.

119. By virtue of, and as a result of, the false records and statements used to get false claims paid by the Government, and/or which were material to any entitlement to any such cost-based payments, the United States has suffered actual damages and is entitled to recover three times the amount by which it is damaged, plus civil money penalties of not less than $5,500 and not more than $11,000 for each of the false claims presented or caused to be presented, and other monetary relief as appropriate.

COUNT III

Claims By and on Behalf of the United States for Conspiracy to Cause Submissions of False Material Statements and False Claims

120. This is a claim under the False Claims Act, 31 U.S.C. §§ 3729-33, as

amended, against each of the Defendants herein.

121. Plaintiff re-alleges and incorporates by reference paragraphs 1 through 108 as though fully set forth herein.

122. By reason of those foregoing allegations, each of the Defendants agreed and conspired with Defendant Wade Walter (and Wade Walters in turn agreed and conspired with each other Defendant herein) to participate in causing the relevant CAH Hospitals to submit false cost reports, false statements, and false claims to Medicare in order to get false or fraudulent cost-based claims paid by Medicare, in violation of 31 U.S.C. § 3729(a)(1)(C). In furtherance of that overall single conspiracy, and through each of the particular activities described above, each of the Defendants acted overtly to affect the objects of the conspiracy alleged herein.

123. By virtue of the resulting false statements in cost reports and false claims caused to be presented by each of the Defendants to Medicare, pursuant to that single conspiracy, the United States has suffered actual damages and is entitled to recover from each of the Defendants three times the amount by which it was damaged as a result of all unlawful per diem payments to all relevant hospitals, plus civil money penalties of not less than $5,500 and not more than $11,000 for each of the false per-diem claims presented or caused to be presented, and other

monetary relief as appropriate.

PRAYER FOR RELIEF

WHEREFORE, the United States demands and prays that judgment be entered in favor of the United States:

1. On Counts I - III, under the False Claims Act, against each of the Defendants herein, for treble (i.e., three times) the amount of the United States' actual damages (including investigative costs), plus civil penalties as are allowable by law for each false claim or record;

2. For all costs and expenses of this civil action, including all investigative and expert expenses incurred herein; and

3. For such other and further relief as the Court deems just and equitable.

WHEREFORE, Relators Mitchell D. Monsour and Stephen Vaughan hereby demand and pray that judgment further be entered in their favor:

1. On Counts I - III, under the False Claims Act, for a percentage of all civil penalties and damages obtained from any of the Defendants pursuant to 31 U.S.C. § 3730, reasonable attorney's fees, investigative costs, expert witness fess incurred, and all costs incurred in pursuing these claims against the Defendants; and

2. Such other relief as the Court deems just and proper.

This the 1st day of July, 2021.

Respectfully submitted,
MITCHELL D. MONSOUR and
WALTON STEPHEN VAUGHAN,
By their Attorneys,
PIGOTT & JOHNSON, P.A.

By: s/Brad Pigott
J. Brad Pigott

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Certificate of Service

This is to certify that I have this day, July 1, 2021, caused service of the foregoing First Amended Complaint on counsel for the Defendants now represented by counsel herein through an electronic filing with the Clerk of this Court through its ECF system, and through service at the below email address of each, and have further caused the same to be served by prepaid United States First Class Mail on Defendants Wayne Walters, CAH Management - Franklin Services LLC, and Revenue Cycle Management - Franklin LLC, at the physical address noted below:

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s/Brad Pigott
J. Brad Pigott