UNITED STATES TAX COURT

Redacted

ROY J. MEIDINGER,	)	
	)	
PETITIONER,	)	
	)	
	)	
	)	
v.	)	**Docket No. 16513-12W**
	)	
	)	
	)	
COMMISSIONER OF INTERNAL REVENUE,	)	
	)	
RESPONDENT.	)	

Supplement to Petitioner's Motion for Summary Judgment

The addendum is to be incorporated into the Petitioner's motion for summary judgment, which is to include all attachments and any legal arguments which may have been overlooked.

1) The Whistleblower Office (WO) History Sheet, dated 11/4/09 shows the 211 form was complete, the power of attorney was attached and the 211 form did identify a Federal Tax Issue and the WO did accept the 211 form. (See Exhibit A).
2) Prior to the whistleblower's claims being sent to the field for investigation a TAINT Review by teleconference was held. (See Exhibit B).
3) The Whistleblower Office did have a copy of the Florida State Laws, Title XXXII Chapter 456.054 kickbacks prohibited and chapter 817.505 Patient brokering prohibited; exceptions; penalties,. The Subject Matter Experts completely ignored these laws. (See Exhibit C).

4) the Whistleblower Office had over 60,000 annual cost reports on two CD's, which the cost reports can be obtained from the Centers of Medicare/Medicaid Services of the Health and Human Services Department. (See Exhibit D).

5) The following discussion refers to the email (See Exhibit E) , sent Thursday, December 08, 2011, 2:12 PM, sent from Subject Matter Expert Cheryl L. Cross to Katherine K Onken, who consulted with Healthcare Technical Advisor Daniel Zink, in which he make some erroneous assumptions:

   a. In the first paragraph he states "I'm not an attorney, and thus can't offer an opinion on the legal validity of that contention"

   b. In the second paragraph he states "The use of contractual allowances is generally accepted accounting principle (GAAP) in use on certified financial of healthcare providers.", he fails to state the accounting principle or under what conditions it is an acceptable practice or state the difference between financial accounting and tax accounting.

   c. In the third paragraph he fails to state when revenue is recognized under the Accrual Accounting Method.

   d. In the third paragraph he states "While TAMs may not be cited as president, they do reflect the opinion of Chief Counsel. The IDD, which references the TAX, was reviewed and approved by Chief Counsel prior to issuance.". In 2007, the Internal Revenue Service issued a memo, LMSB-04-0807-056, Tier II Industries Director's Directive on the Planning and Examination of Contract Adjustment Issues in the Healthcare Industry #2, in the introduction of the LMSB memo includes a disclaimer: "This directive is not an official pronouncement of law or

of the position of the Service (IRS) and cannot be used, or cited, or relied upon as such".

e. Throughout Mr. Zink's paragraphs he makes further assumptions about accrual accounting, creation of indebtedness, bad debt, "a legally enforceable contract" or tax law, always referring to documents which are not or claim to be tax laws. He did state he is no attorney, he does not have any legal authority to determine if a legal contract granting lower payment rates is in force, and it seems he has never looked at a contract between the patient and the hospital or the contract between the hospital and the third party payer, the insurance company. He has absolutely no credibility.

f. I wrote an article entitled **"Misuse of the Contract Adjustment Account in the Health Care Industry** in which I contradict all of Mr. Zink's comments and assumptions; and, list the applicable laws which apply to this case. (See Exhibit F).

6) For the Courts Benefit I am attaching as examples two contracts, the contract of the patient and the hospital and the contract between the hospital and the health insurance company. (See Exhibit G)

Dated June 8 2013

Roy J. Meidinger /s/ Pro Se
ROY J. MEIDINGER Pro SE
Petitioner
[redacted]

Exhibit A

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Doe% the Form 2I I identify a
Federal I Issue

Claim Identified as a 7623(a)

Research database for existing or previous case number.

Previous 1-Trak Case Number NO Claim.Case Number

ICE 11eb Claim Number n

Acknovtledgement Letter 1ES Date Completed:

Date Case Forwarded to ICE

Claim Identified a a 7623(b)
Research database for •xistin previous case number.

Previous Irak *Case* Number NO Claim:Case Number

ICE Web Claim Number 1,9-7/0?6

1DRS Research Completed n E S Date Completed

Entered into e- rRAK Case

Assigned to:

teknovvIedgement Letter

Case Forwarded to Analst

1000027

Exhibit B

By my signature below, I certify that the above information was discussed on the dates indicated.

IRS Representative:	**Date:**
Cheryl Crow, Internal Revenue Agent	2/3/11
Informant's Signature:	**Date:**
Representative signature	**Date:**

Conference or	Method of Contact **Conference Call**	Date: **2/3/2011**	Time: **2:00 pm EST**
Contact Memorandum	Phone: (X)	In Person ( )	
Initiator **Cheryl Cross, EO Taint Reviewer**	Person contacted or Participants **Cheryl Cross, IRS, EO Taint Reviewer** **William Miller, TEGE Counsel** **Roy *j.* Meidinger, Whistleblower** **Thomas C. Pliske, Whistleblower POA**		
Office or Place of Conference **Teleconference**	Reference WB Claim #2010-000785		

Subject Matter/Remarks:

At the beginning of the call, Cheryl Cross read to the Whistleblower and his Attorney the information contained on the Debriefing Checksheet.

In these notes, the whistleblower Roy Meidinger will be referred to as WB and his POA Thomas Pliske will be referred to as WB-POA.

1. **The WB went to college at night and obtained a B.S. from Pace University. Courses he took included law and accounting. He worked for AT&T as a technician on the switching machine. He later transferred to Bell Laboratories as a *part* of a think tank. He received heavy training as a system analyst. He took an early management retirement from AT&T. He is married to a wife of 48 years and have** 3 **children.**

2. **The WB has been involved in this investigation since 1994 (healthcare). He used to be a caretaker for his parents. He got the Labor & Commerce dept to change their price indexes. He was helpful to Senator Kennedy.**

3. **The WB stated that the taxpayers to which the allegations apply are:**

   a
   b
   c
   d
   e
   f All of the insurance companies listed on page 4-122 of the submission (List of *each* health insurer with whom the hospital has a PPA contract)

4. **He filed two qui tam cases which have been dismissed. He has no plans of filing again as long as the healthcare system has been fixed.**

Conference or	Method of Contact **Conference Call**	Date: **2/3/2011**	Tune: **2:00 pm EST**
Contact Memorandum	Phone: (X)	In Person ( )	
Initiator **Cheryl Cross, EO Taint Reviewer**	Person contacted or Participants **Cheryl Cross, IRS, EO Taint Reviewer** **William Miller, TEGE Counsel** **Roy J. Meidinger, Whisdeblower** **Thomas C. Pliske, Whisdeblower POA**		
Office or Place of Conference **Teleconference**	Reference WB Claim #2010-000785		

Subject Matter/Remarks:

a. should not have been allowed to declare a deduction on their return for the contractual allowance. The write-off is not allowable. The two parties to which this issue applies is nd the Insurance Companies.

is liable for the issuance for Form 1099-C for the forgiveness of debt they gave each of the insurance companies. (The insurance companies to which this allegation applies are listed on page 4-122).

c. The insurance company should have included the differences as income on their tax return.

d. The insurance companies base their premium on the billed amount. If it is not corrected quickly, the premium will remain high and people will continue to suffer because of their method of accounting.

15. In regards to Issue #2 Barter Income the WB states that the taxpayer to which this allegation applies to is the (medical provider) and the Insurance Companies listed on page 4-122. (The insurance companies send patients for a reduction in customary charges)

16. In regards to Issue #3 Kickbacks, the WB asserts that is making the "kickback" (which is not a legal deduction) and the Insurance companies are receiving it and not reporting it as income.

17. The WB indicates that Issue #4 a ies to The WB asserts that the employees o are not billed anything when they obtain medical services from . In addition to Health Insurance, all employees o are entitled to receive medical services from the system at no charge. He asserts that this should be a taxable fringe benefit. He refers to Line 16 of page 4-63 **of his exhibits (Employee Discounts). The WB stated that in various interviews with the person who at the time was the accountant**

Conference or	Method of Contact **Conference Call**	Date: **2/3/2011**	Tune: **2:00 pm EST**
Contact Memorandum	**Phone: (X)**	**In Person ( )**	
Initiator **Cheryl Cross, EO Taint Reviewer**	**Person contacted or Participants** **Cheryl Cross, IRS, EO Taint Reviewer** **William Miller, TEGE Counsel** **Roy J. Meidinger, Whistleblower** **Thomas C. Pliske, Whistleblower POA**		
Office or Place of Conference **Teleconference**	**Reference** **WB Claim #2010-000785**		

Subject Matter/Remarks:

5_ In Chapter 4 Exhibits, Exhibit 1 the WB points out that patient contracts stands alone. The billing is put on the accounts receivable of the patient. Both parties agree that the insurance company owes it. The WB prepared this chart himself

6. **Exhibit 3.5 and 3.6 came from the website.**

7. **The WB stated that discounts are given to non-insured patients now. This is different from an actual kickback. He feels the uninsured was paying five times more than the insured.**

8. **The information on page 4-50 came from thellMlealthcare Finance Administration.**

9. **The information on page 4-58 came from the State of The WB points out that on the billing report everyone gets billed the same. His point is that people cannot be paid for brokering. Forgiveness of debt is taxable unless specifically excluded. In this chart Total Patient Revenue shows what was billed. Total Deduction from Revenue shows what was billed to insurance companies.**

10. **The information on page 4-61 came from the Healthcare Finance Administration. The WB states that the hospital know they are not giving discounts. They are giving compensation. This is taxable income to the insurance companies.**

11. **The information on page 4-69 is legal research he paid for.**

12. **The information on page 4-74 came from the website.**

13. **The WB-POA stated that the WB picked for no good reason. He chose this entity because it is the hospital that *he* is familiar with. This issue does not apply for only. The issue applies to every medical provider in the country. All of the federal and state laws are clear about this.**

14. **In regards to Issue #1 Cancellation of Indebtedness the WB states the following:**

or	Method of Contact: **Conference Call** Time:	Date: **2/3/2011**	**2:00 pm EST**
Contact Memorandum	Phone: (**X)**	**In** Person ( )	
Initiator **Cheryl Cross, EO Taint Reviewer**	Person contacted or Participants **Cheryl Cross, IRS, EO Taint Reviewer** **William Miller, TEGE Counsel** **Roy J. Meidinger, Whistleblower** **Thomas C. Pliske, Whistleblower POA**		
Office or Place of Conference **Teleconference**	Reference W-13 Claim #2010-000785		

Subject Matter/Remarks:

for MIMI, he learned of these this taxable fringe benefit.

18. In re ards to Issue #5 Pa ent/Deduction of Kickback, the WB asserts that the taxpayer pays an "illegal" patient referral fee of $450 per patient to totaling approximately $5,000,000 per year. He does not **know** how these amounts were reported on the books and records of either entity and he knows of no documentation that exists to prove this. He indicated that he received this knowledge pursuant to an interview with a doctor o . (He is a patient of the doctor). The doctor's name **is .** The doctor is the one that informed him that the amount paid was $5,000,000 a year. This doctor is no longer with

The WB allegation is that paying for patient care is illegal.

Exhibit C

456.054 Kickbacks prohibited.--

(1) As used in this section, the term "kickback" means a remuneration or payment, by or on behalf of a provider of health care services or items, to any person as an incentive or inducement to refer patients for past or future services or items, when the payment is not tax deductible as an ordinary and necessary expense.

(2) it is unlawful for any health care provider or any provider of health care services to offer, pay, solicit, or receive a kickback, directly or indirectly, overtly or covertly, in cash or in kind, for referring or soliciting patients.

(3) Violations of this section shall *be* considered patient brokering and shall be punishable as provided in s. 817.505.

History.--s. 8, ch. 92-178; s. 2, ch. 96-152; s. 79, ch. 97-261; s. 8, ch. 99-204; s. 78, ch. 2000-160; s. 6, ch. 2006-305.

Select Year: 2007 Go

Tior' 17
CRIMES FRAUDULENT PRACTICES

817.505 Patient brokering prohibited; exceptions; penalties.--

(1) It is unlawful for any person, including any health care provider or health care facility, to:

(a) Offer or pay any commission, bonus, rebate, kickback, or bribe, directly or indirectly, in cash or in kind, or engage in any split-fee arrangement, in any form whatsoever, to induce the referral of patients or patronage to or from a health care provider or health care facility;

(b) Solicit or receive any commission, bonus, rebate, kickback, or bribe, directly or indirectly, in cash or in kind, or engage in any split-fee arrangement, in any form whatsoever, in return for referring patients or patronage to or from a health care provider or health care facility;

(c) Solicit or receive any commission, bonus, rebate, kickback, or bribe, directly or indirectly, in cash or in kind, or engage in any split-fee arrangement, in any form whatsoever, in return for the acceptance or acknowledgement of treatment from a health care provider or health care facility; or

(d) Aid, abet, advise, or otherwise participate in the conduct prohibited under paragraph (a), paragraph (b), or paragraph (c).

(2) For the purposes of this section, the term:

(a) "Health care provider or health care facility' means any person or entity licensed, certified, or registered; required to *be* licensed, certified, or registered; or lawfully exempt from being required to be licensed, certified, or registered with the Agency for Health Care Administration or the Department of Health; any person or entity that has contracted with the Agency for Health Care Administration to provide goods or services to Medicaid recipients as provided under s. ')17; a county health department established under part I of chapter 154; any community service provider contracting with the Department of Children *and* Family Services to furnish alcohol, drug abuse, or mental health services under part IV of chapter 394; any substance abuse service provider licensed under chapter 397; or any federally supported primary care program such as a migrant or community health center authorized under ss. 329 and 330 of the United States Public Health Services Act.

(b) "Health care provider network entity" means a corporation, partnership, or limited liability company owned or operated by two or more health care providers and organized for the purpose of entering into agreements with health insurers, health care purchasing groups, or the Medicare or Medicaid program.

(c) "Health insurer" means any insurance company authorized to transact health insurance in the state, any insurance company authorized to transact health insurance or casualty insurance in the state that is offering a minimum premium plan or stop-loss coverage for any person or entity providing health care benefits, any self-insurance plan as defined in s. •).1.:1; i, any health maintenance organization authorized to transact business in the state pursuant to part I of chapter 641, any prepaid health clinic authorized to transact business in the state pursuant to part II of chapter 641, any prepaid limited health service organization authorized to transact business in this state pursuant to chapter 636, any multiple-employer welfare arrangement authorized to transact business in the state pursuant to ss. [1]. •• ' -624.45, or any fraternal benefit society providinvi

health benefits to its members as authorized pursuant to chapter

632. (3) This section shall not apply to:

(a) Any discount, payment, waiver of payment, or payment practice not prohibited by 42 U.S.C. s. 1320a-7b(b) or regulations promulgated thereunder.

(b) Any payment, compensation, or financial arrangement within a group practice as defined in s. • =•-• provided such payment, compensation, or arrangement is not to or from persons who are
not members of the group practice.

(c) Payments to a health care provider or health care facility for professional consultation services.

(d) Commissions, fees, or other remuneration lawfully paid to insurance agents as provided under the insurance code.

(e) Payments by a health insurer who reimburses, provides, offers to provide, or administers health, mental, health, or substance abuse goods or services under a health benefit plan.

(f) Payments to or by a health care provider or health care facility, or a health care provider network entity, that has contracted with a health insurer, a health care purchasing group, or the Medicare or Medicaid program to provide health, mental health, or substance abuse goods or services under a health benefit plan when such payments are for goods or services under the plan. However, nothing in this section affects whether a health care provider network entity is an insurer required to be licensed under the Florida Insurance Code.

(g) Insurance advertising gifts lawfully permitted under s. (1)(m).

(h) Commissions or fees paid to a nurse registry licensed under s. -ic:O.''3(` for referring persons providing health care services to clients of the nurse registry.

(i) Payments by a health care provider or health care facility to a health, mental health, or substance abuse information service that provides information upon request and without charge to consumers about providers of health care goods or services to enable consumers to select appropriate providers or facilities, provided that such information service:

1. Does not attempt through its standard questions for solicitation of consumer criteria or through any other means to steer or lead a consumer to select or consider seleCtion of a particular health care provider or health care facility;

2. Does not provide or represent itself as providing diagnostic or counseling services or assessments of illness or injury and does not make any promises of cure or guarantees of treatment;

3. Does not provide or arrange for transportation of a consumer to or from the Location of a health care provider or health care facility; and

4. Charges arid collects fees from a health care provider or health care facility participating in its services that are set in advance, are consistent with the fair market value for those information services, and are not based on the potential value of a patient or patients to a health care provider or health care facility or of the goods or services provided by the health care provider or health care facility.

(4) Any person, including an officer, partner, agent, attorney, or other representative of a firm,

Exhibit D

Roy J. Meidinger
14893 American Eagle Court
Fort Myers, Fl. 33912
239-694-5597
Cell # 954-790-9407

April 15th, 2007

Department of the Treasury
Internal Revenue Service
Criminal Investigation Division
Bryan Tucker — Special Agent
Metro Center 1
2891 Center Point Dr. Suite 201
Ft. Myers, Fl 33916

Re: Tax Evasion by Health Industry Oligopoly

Dear Bryan

I am enclosing two CD's with all of the Hospital Cost Reports, CMS 2552-96, from the years FY1996 through the Current year. You now have in your possession over 60,000 cost reports. You can easily calculate the total amount of kickbacks given by the hospitals to the health insurance companies, by year, for each hospital. It will take a little calculation on your part: 1) the report lists the total amount of third party deductions, which include Medicare, Medicaid and the insurance companies. 2) To determine the amounts written off to the Medicare and Medicaid programs, find the total amount charged to these programs and subtract the total amounts paid by these programs. The difference is what is written off. 3) Subtract the amount written off to the Medicare and Medicaid programs from the total amount written off and the answer is the amount of the kickbacks. This amount is taxable income for both the hospital and the insurance companies.

You should get copies of the filed CMS form 339 for each hospital, for each of the years involved. These forms will list the financials and the individuals you should file tax evasion charges against, for the hospitals. You may also want to get copies of the yearly tax returns, for Not-For-Profit corporations it is form 990.

I would advise you to keep Assistant US Attorney Jamie Yavelberg, in Washington DC, informed of your progress. I believe she may have a group investigating all the charges working in Tampa. If you determine the bills or claims, the UB92's, sent to the insurance companies are false the penalty I believe is $25,000 and three years in prison for each false claim. The hospitals should have read the back of the form, before they certified it correct and sent it forward to the insurance companies; although, both the hospitals and the insurance companies conspired to defraud the government and everyone else.

You may want to also notify the postal services about mail and wire fraud. You can also notify the Office of Inspector General of Health and Human Services all of their Fiscal

Intermediaries are committing fraud. You can down load a list from the CMS web site, and make sure I listed every one of them.

It is a shame these illegal practices were not stopped years ago. I have heard an estimate the Health Industry is causing over a trillion dollars in damages a year. The problem is you must completely fix the entire industry and not just try to fix the government programs. Each day the industry is allowed to continue in these illegal practices fin˙ther hurts the nation. Only traitors would allow this to continue.

Respectfully yours,

Roy J. Meidinger

PS: You can get a copy and explanation of the cost report at the following link:

Exhibit E

Onken Katherine K

From: Cross Cheryl L
Sent: Thursday, December 08, 2011 2:12 PM
To: Onken Katherine K
Subject: FYI--Form 211 with Allegations of Tax Non-Compliance
Importance: Low
Attachments: TAM200619020.doc; Contractual Allowances IDD.pdf; ABA Article.pdf; BCBS Article.pdf Kathy,

During my review of the claim, I consulted with Healthcare Technical Advisor Daniel Zink. You may want to invite him if he is available.

Cheryl Cross

From: Zink Daniel S
Sent: Thursday, February 17, 2011 4:49 **PM To:** Cross Cheryl L **Subject:** RE: Additional Information
Importance: Low

Hi Cheryl. I reviewed the information you sent, and give you my thoughts on the contractual " adjustment piece. I'm not really qualified to opine on any of the other items. It seems that the primary contention underlying all of the whistieblowers positions is that a patient is liable to the provider for the standard charge regardless of any contract between the provider and a third-party payer associated with the patient. I'm not an attorney, and thus I can't offer an opinion on the legal validity of that contention. I will try to provide some details and documentation on financial accounting standards, tax law, and how the system works in practice. I believe all of these will demonstrate that neither providers, patients, payers, or regulators agree with the whistleblower's contention.

The second paragraph on page 1-7 refers to "accounting manipulations". I assume this refers to the recording of charges at a standard cost, and the use of contactual allowance reserves to reduce accounts receivable to an amount that will actually be received based on a contract in force with a third-party payer. The use of contractual allowances is generally accepted accounting practice (GAAP) in use on the certified financial statements of healthcare providers. As such, it is accepted by the SEC for use in the financial reporting of public company healthcare providers. Contractual allowances are not "accounting manipulations". They are, instead, the approved financial accounting method for presenting accounts receivable and related income.

From a tax perspective, contractual allowances have been found to be proper where they are used in a manner that clearly reflects income for tax purposes. TAM 200619020 and a September, 2007 industry Director's Directive (IDD) on Contactual Allowance Issues in the Healthcare Industry are attached. (The IDD is referenced at the bottom of page 1-7, with the notation that it contains an incorrect assumption; clearly, it would not have been issued if the Service believed that it was based on an incorrect assumption.) While TAMs may not be cited as precedent, they do reflect the opinion of Cheif Counsel. The IDD, which references the TAM, was reviewed and approved by Chief Counsel prior to issuance. Some primary points from the TAM that are pertinent to the issue at hand:

TAM

The TAM concludes, in part, that "1) An accrual basis taxpayer generally may exclude "contractual allowances" from total receivables in determining gross income if there exists, at the time a service is performed or a good is provided, a legally enforceable contract that provides that the payor incurs a

standard billed charge for the same service/good. Where no such contract exists at the time the service is performed or the good provided, however, no exclusion for a "contractual allowance" is warranted.", and that "2) The amount which may be properly taken into account as a "contractual allowance" consists solely of the difference between the amount that is billed for a service/good and the amount which the taxpayer may legally collect from the responsible payor under the terms of a legally enforceable contract in existence at the time the service is performed or good is provided."

"While the field and the Taxpayer agree conceptually that contractual allowances may be excluded from total receivables in determining gross income to the extent the rights to such contractual allowances are set forth under the terms of legally enforceable contracts, the field and the Taxpayer disagree on whether the *amount* of the contractual allowance can be determined using estimates or must be determined utilizing the actual contractual information available at the end of each taxable year."

"This contractual allowance does not constitute bad debt because the taxpayer is not entitled to receive the standard charge."

The disagreement between the field and the taxpayer addressed in the TAM is not related to the concept of contractual allowance. Rather, it is a question of the computation of the amount that should be taken into account for tax purposes. The TAM makes it clear that the Service fully recognizes the concept of contractual allowance as a reduction to standard charge. In addition, the TAM provides that the contractual allowance does not constitute bad debt since there is never an entitlement to receive the full standard charge. Where there is no debt, there can be neither bad debt nor forgiveness of debt .

Section 448(d)(5) of the Internal Revenue Code provides a non-accrual experience method of accounting with regard to bad debts. Section 1.448-2(c)(1)(i) of the Income Tax Regulations states that "accounts receivable do not include...amounts contractually not collectible (such as amounts in excess of a fee schedule agreed to by contract)." Section 1.448-2(g) Example 1 of the Income Tax Regulations provides the following:

Example 1 Contractual allowance or adjustment. B, a healthcare provider, performs a medical procedure on individual C, who has health insurance coverage with IC, an insurance company. B bills IC and C for $5,000, B's standard charge for this medical procedure. However, B has a contract with IC that obligates B to accept $3,500 as full payment for the medical procedure if the procedure is provided to a patient insured by IC. Under the contract, only $3,500 of the $5,000 billed by B is legally collectible from IC and C. The remaining $1,500 represents a contractual allowance or contractual adjustment. Under paragraph (c)(1)(i) of this section, the remaining $1,500 is not a contractually collectible amount for purposes of this section and B may not use a nonaccrual-experience method with respect to this portion of the receivable.

The other attached files are articles discussing co-payments and deductibles. The BCBS Article is from 1995, and is an indication of the controversy surrounding insurance practices regarding co-payments at the time. The fact that those practices were addressed judicially and legislatively is an indication that the contractual provisions between insurer and provider were considered applicable to all parties. (Note that even in the fact pattern of the article the providers were in principle collecting the contracted co-payment - the controversy involved how to compute that co-payment) The ABA Article is current, and discusses the insurance industry's attempts to make sure providers collect co-payments and deductibles. The article includes a good discussion of how on-network and off-network provider payments are computed. Particularly note the last two paragraphs of page 1, and the section titled "Contractual Waiver of Co-Payments and Deductibles" on page 2. The conclusion in the article is that insurers and, to some extent, states and the federal government, have concerns when providers do not collect the amount of co-payment or deductible contractually prescribed. However, there is no indication that any further amount is owed by the patient or could be collected by the provider under a theory that the contract between insurer and provider does not relieve the patient of full liability.

I hope this helps. Once you have a chance to look over the information here, please give me a call and we can discuss further.

Daniel 5. Zink

Technical Advisor - Health Care
810 Broadway, Suite 500
Nashville, **TN** 37203
(615) 250-5195

Exhibit F

Misuse of the Contract Adjustment Account in the Health Care Industry

by Roy J. Meidinger

May 21, 2013

1) In 2007, the Internal Revenue Service issued a memo, LMSB-04-0807-056, Tier II Industries Director's Directive on the Planning and Examination of Contract Adjustment Issues in the Healthcare Industry #2, to its auditors to clarify the proper use of the contract adjustment account for determining taxable income within the health care industry. The problem identified was the standard industry practice of billing an insured patient the standard rates, but allowing their health insurance company to pay a much lower amount. The LMSB memo contained several legal flaws. The memo failed to distinguish the difference between the patient's contract with the hospital for services; the creation of the indebtedness; the right to collect the billed charges; and the hospital's contract with the health insurance company. The memo also failed to take into consideration all of the applicable laws which help protect consumers in the health care industry.

2) This article, regarding misuse of the "contract adjustment account", concentrates on the largest users of this non-standard accounting procedure which are hospitals and the health insurance companies; and the tax consequences which have been created in the health care industry; but is applicable to all health care providers. The introduction of the LMSB memo includes a disclaimer: "This directive is not an official pronouncement of law or of the position of the Service (IRS) and cannot be used, or cited, or relied upon as such".

3) The main premise of the LMSB memo states that if a legally enforceable contract existed at the time the medical services were provided granting a discount to the insurance company, then the amount billed to an insured member would not be recognized as taxable revenue. The memo also states that the hospital and insurance company are allowed to use the contract adjustment account to write off the difference of the amount billed and the actual amount paid. According to the memo, this is an acceptable practice under Generally Acceptable Accounting Practices for corporations within the Accrual Method of Accounting.

4) The use of the contract adjustment account can be traced to the beginning of the Medicare/Medicaid programs. The government created this new accounting methodology within the Accrual Method of Accounting when it started the Medicare/Medicaid Programs fifty years ago. This is the first time the amount listed on a bill was not accurate and therefore a reconciliation account for balancing accounts, known as the "Contract Adjustment Account", had to be used. The Social Security Law required the "customary charge", which is the medium amount actually collected from all the charge-paying patients, rather than the standard amount. The invoice was no longer a bill because the

Government never intended to pay the amount listed but was to be used as a source of information to determine what was actually being paid in the private sector. During this time, the government only paid for the costs incurred by the beneficiaries and the charges listed on the invoice were used to apportion the costs. The "Contract Adjustment Account" was to be used only for government programs. The legal requirement for the customary charge is written in the Social Security Law and within the Hospital's Medicare/Medicaid billing manual.

5) In the health care industry, all private-pay patients are to be treated the same and billed the same standard charge for the same services. These standard charges are listed in the hospital's chargemaster. The same billing charge for all private-pay patients is guaranteed by both the state and federal antitrust laws; it is known as price discrimination if the amounts charged are different. United States antitrust law is a collection of federal and state government laws which regulate the conduct and organization of business corporations, generally to promote fair competition for the benefit of consumers. The main statutes are the Sherman Act 1890, the Clayton Act 1914 and the Federal Trade Commission Act 1914. These acts deal with price discrimination, price fixing, boycotts and restraint of trade. These laws originally dealt with only commodities, but in 1944 this changed when the Supreme Court declared insurance to be a commodity.

6) When a service is completed, a patient's bill is issued listing all the standArd charges listed in the hospital's chargemaster. The billed amount is then posted to the patients' accounts receivables and recognized as income to the hospital. A bill is then sent to the non-insured private-pay patients listing all services and medical items, along with the standard charges, which is the legal obligation of the patient. In the case of an insured private-pay patient the bill is first sent to the insurance company for payment. However, providers have contractual agreements with the vast majority of third-party payers regarding the amount that the payer will reimburse for specific goods and services (i.e., the contract provides for a discount for enumerated goods and services). The amount of discount typically differs in contracts between a provider and different payers and, in fact, often differs between different insurance plans offered by the same payer.

7) These billed amounts are certified correct when sent to third party payers, by the use of either the Uniform Billing Forms CMS 1500 or UB 04 which, if false, is subject to a fine, imprisonment or both. It is a felony crime to submit a false bill or invoice to a third party payer. In the legal system for Bills and Notes, the amount listed on a bill is a material fact and is the legal obligation. If a legal discount is to be given, it must be listed on the bill at the time of issuance and the net amount listed on the bill. The net amount should also be listed on the patient's account receivable. This amount billed is the actual amount recognized for the computation of taxable income.

8) There is a different methodology for recognizing income for financial reports and tax returns. Also, there are different accounting methodologies used for government beneficiaries and private-pay patients. The private-pay patients, both insured and uninsured, also known as charge-paying private-pay patients, are billed the standard rates

or usual charge. Government beneficiaries, because of the Social Security law, are billed the customary charge. The standard charge represents the legal obligation, which is also the creation of the indebtedness, and the actual amount to be collected.

9) Up until 30 years ago, the standard charge or the usual charge, and the customary charge were the same amount. Then, in 1983, the government introduced the Prospective Payment System for the Medicare and Medicaid Programs, whereby it utilized the Diagnostic Related Groups (DRG's) which had a fixed rate assigned to each DRG and these rates were determined by Congress. These rates were increased for the next year utilizing a basket full of economic items. One of the items used was the current customary charge listed on the beneficiaries' invoices, the universal bill submitted to the Medicare/Medicaid Programs. "42 CFR 405.503(a). Under 42 CFR 413.13 (e) (2) Customary Charges are reduced in proportion to the ratio of the amounts actually collected from charge-paying non-Medicare patients to the amount that would have been realized had customary charges been paid and the provider (i) Did not impose charges in the case of most patients liable for payment for its services on a charge basis; or (ii) Failed to make a reasonable effort to collect these charges." What this section means is the customary charge is determined by the average amount of all the monies actually collected from all the private-pay patients for the same service.

10) The indebtedness or legal obligation of the private-pay patient is created when the services are completed and the bill is issued, which is the standard for the Accrual Method of Accounting. A patient's contract is clear, precise and it stands alone. Parole evidence cannot be introduced to change the terms of the patient's contract with the hospital. The patient guarantees the payment of all medical items and medical services billed. A patient's contract is an enforceable contract and is not supplemented by the insurance companies' contracts. These are the contracts the hospital enforces in civil courts for payment of debts owed or sells them to collection agencies.

11) The IRS has a two-prong test it uses for determining taxable revenue. First, it relies on documentation that the services were performed, such as the patients' bills; the universal bill UB-04; the hospital's chargemaster, which lists all of the standard charges; and the patients' accounts receivables. Second, and most importantly, the IRS relies on the contract between the patient and the health care provider.

12) Like any promissory note, if a legal discount is provided to the patient, it must be listed on the bill at the time of issuance with the net amount listed on the bill and recorded on the patient's account receivable. The transaction between the hospital and the third party payer, the health insurance company is not a re-pricing of the bill. For Internal Revenue Service and contract law, the legal obligation is determined by the face amount on the patient's bill.

13) Health insurance companies base their premiums on what their members are billed by health care providers. These premiums must cover the full amounts billed, which are the legal obligations of its members. The insurance companies do not base their premiums on

what they pay for the medical services provided to their members. Therefore, when a patient sees an Explanation of Benefits (EOB) statement from the insurance company, it shows both figures: the amount the member was billed, which is the patient's legal obligation; and the amount the insurance company paid, which includes the co-payments. The difference is the kickback the health care provider paid the insurance company for coercing the member to use the services of the health care provider.

14) The insured private-pay patient is never billed on the original bill for co-payments, stop-loss limits and deductibles by the health care providers, these items are not listed in the hospital's chargemaster. These billable amounts are legal obligations the members owe to the insurance companies. The insurance company must track how much is owed on the deductible; the co-payment; determine any amount which might exceed the members limit; and determine whether or not the insurance company is going to pay for the procedures. If the insurance company approves payment, it requests that the hospital collect the amount owed to it by its members and to apply it against the payment. The insurance company requests the health care provider to collect these amounts, rather than billing its member for it. If, during the billing process, the member cannot pay these amounts it is not a bad debt for the health care provider. Instead, this situation necessitates that the health care provider collects these amounts from the health insurance company; this is the same method used with the Medicare Program, where the government is liable for any unpaid co-payments. A note receivable turns into a bad debt when there is no longer a chance of collecting the amount owed. However, the IRS does require that a reasonable attempt to collect the debt is made to prove it is worthless.

15) The hospital gives no discounts to the health insurance companies. The hospitals are the customers of the health insurance companies. There are no account receivables in the health insurance companies name for services rendered. The insurance companies are not the hospitals' customers. There is no re-pricing of services. If any discounts are to be given, the insurance companies should give them to the hospitals. But the insurance companies never issue bills to the hospitals. Assumption of indebtedness exists when a person binds himself to pay debt incurred by another. Pawnee County Excise Board v. Kurn, 187 Okl. 110, 101 P.2d 614, 618.

16) Price adjustments that are illegal are generally treated as reductions of the sales proceeds when they are made between the buyer and seller directly, as opposed to reflecting them as nondeductible expenses. However, in cases where the price adjustments are made between the parties other than the buyer and the seller, the sales reported are increased to the original invoice amount and a corresponding nondeductible expense item is reported for the illegal payment.

17) The insurance company purchases no medical services or medical supplies from the hospital, therefore incurs no liability on its own. The only liability the insurance company obtains is the legal liability of its insured member. The insurance company is not an agent of its insured member and has no right to negotiate any discounts for its insured members. The lower amounts actually paid are for its own benefit for services rendered.

18) The contract between the health care provider and the health insurance company make the health care provider the customer, the purchaser of services from the health insurance company. The consideration paid by the provider is the forgiveness of debt owed by the insurance company's member. The consideration provided by the insurance company, the seller, is the financial coercion of its members to use the medical services of the provider and boycott other health care providers. The coercion is an agreement by both parties, which calls for the insurance companies' members' co-payment to be increased if the member uses an off-network provider. The contract between the health care provider and the health insurance company is for illegal purposes. It calls for a restraint of trade and a boycott of other health care providers. It calls for the price fixing of a third party, the member of the insurance company.

19) There is a myth that the health insurance companies bring their members to the hospital and should receive a bulk discount because of lowered cost. This is partially true and partially false. It is true that the more patients a hospital has, the lower its average cost of handling services for all patients becomes, also known as economy of scale. But the important point is that all patients' costs go down because it is an average cost, also known as overhead absorption. The health care laws and the state and federal price discrimination laws are very specific. In order to not shift costs to one group of patients, all patients must be charged the same and maintain the same price-to-cost ratios. Therefore, all patients must be charged the same price for the same services and have the same legal obligation.

20) When Congress legalized HMO's in 1976, it included several protections for the insured HMO members. The law calls for the complete payment of the members' legal obligation for medical services and for a small fixed amount to be billed in the case where the member uses an off-network provider. It does not call for a variable amount, or a percentage of the total amount billed to be charged. This would mean almost every member would be billed a different amount for doing the same thing when using an off-network provider.

21) The law that created the HMOs and PPOs, Title 42, Chapter 6A, Subchapter XI, § 300e: Requirements of Health Maintenance Organizations: (7), is quite specific in its contractual requirements. It states that health insurance companies must fully pay the legal obligation of its members when they use the services of a hospital which the insurance company has a contract with. The insured member of the HMO or PPO is charged the same amount as a non-insured private-pay patient and has the same legal obligation; the methodology of payment does not change the legal obligation.

i. 42 USC § 300e - Requirements of health maintenance organizations:
   1. Manner of supplying basic and supplemental health services to
   2. members;
   3. A health maintenance organization shall provide, without limitations as to time or cost other than those prescribed by or

under this subchapter, basic and supplemental health services to its members in the following manner:

ii. Each member is to be provided basic health services for a basic

1. health services payment which;
2. (b.) (D) may be supplemented by additional nominal payments which may be required for the provision of specific services (within the basic health services), except that such payments may not be required where or in such a manner that they serve (as determined under regulations of the Secretary) as a barrier to the delivery of health services. Such additional nominal payments shall be fixed in accordance with the regulations of the Secretary.
   If a health maintenance organization offers to its members the opportunity to obtain basic health services through a physician not described in subsection (b)(3)(A) of this section, the organization may require, in addition to payments described in clause (D) of this paragraph, a reasonable deductible to be paid by a member when obtaining a basic health service from such a physician.
3. c. (c) Organizational requirements;
   a. Each health maintenance organization shall;
   b. (7) adopt at least one of the following arrangements to protect its members from incurring liability for payment of any fees which are the legal obligation of such organization;
   c. (A)a contractual arrangement with any hospital that is regularly used by the members of such organization prohibiting such hospital from holding any such member liable for payment of any fees which are the legal obligation of such organization;

22) 21)Included within the insurance company's contract is a clause which states that the insurance company assumes all medical liabilities and the insured member is not to be billed for any medical services provided. "Assumption of Indebtedness Exists when person binds himself to pay the debt incurred by another." Pawnee County Excise Board v. Kurn, 187 Oki. 110, 101 P.2d 614, 618.

23) 22)The initial entry of the hospital would be to record the invoice in the amount of services rendered and other costs billed. The total amount invoiced would be recorded as a receivable from the patient and an equal amount is reported as taxable income by the hospital. Income is recorded by the hospital at the time when all the events have occurred which determine the hospital's right to receive it, and the amount can be determined with reasonable accuracy, irrespective of the fact that the taxpayer hospital later forgives the obligation to make payment (Regs. 1.451-1(a)). This would be at the time services are invoiced to the patient. "Although this case involves the accrual of income under § 451, the all-events test for determining the accrual of deductions under § 461 also requires that the amount of the liability must be determined with reasonable accuracy. See § 1.461-

1(a)(2)(i). The Service has acknowledged that the last event necessary to establish the fact of liability under the all-events test of § 1.461-1(a)(2)(i) is the same event that fixes the right to receive income under the all-events test of § 1.451-1(a). Rev. Rul. 98-39, 1998-2 C.B. 198. Accordingly, interpretations of the reasonable accuracy prong of the all-events test of § I .4611(a)(2)(i) are applicable in analyzing the reasonable accuracy prong of the all-events test of § 1.451-1(a)." Pawnee County Excise Board v. Kurn, 187 Old. 110, 101 P.2d 614, 618.

24) The forgiveness of debt given by the health care provider is a non-deductible tax item since it is being paid for having the health insurance company refer members and/or coerce members to use the health care provider. The tax laws clearly cover this un-allowed deduction. Both Federal and State laws make this practice a felony crime. Generally, deductions are not allowed for payments that constitute a bribe, kickback or other payment that is illegal under any law of the United States or under any generally enforced law of a state subjecting the payer to a criminal penalty or the loss of license or privilege to engage in a trade or business (IRC §162(c)(2) & (3)

a. 26 USC § 162 - Trade or business expenses:

b. Illegal bribes, kickbacks, and other payments:

c. (2)Other illegal payments:

d. No deduction shall be allowed under subsection (a) for any payment (other than a payment described in paragraph (1)) made, directly or indirectly, to any person, if the payment constitutes an illegal bribe, illegal kickback, or other illegal payment under any law of the United States, or under any law of a State (but only if such State law is generally enforced), which subjects the payer to a criminal penalty or the loss of license or privilege to engage in a trade or business. For purposes of this paragraph, a kickback includes a payment in consideration of the referral of a client, patient, or customer. The burden of proof in respect of the issue, for purposes of this paragraph, as to whether a payment constitutes an illegal bribe, illegal kickback, or other illegal payment shall be upon the Secretary to the same extent as he bears the burden of proof under section 7454 (concerning the burden of proof when the issue relates to fraud).

e. (3)Kickbacks, rebates, and bribes under Medicare and Medicaid:

f. No deduction shall be allowed under subsection (a) for any kickback, rebate, or bribe made by any provider of services, supplier, physician, or other person who furnishes items or services for which payment is or may be made under the Social Security Act, or in whole or in part out of Federal funds under a State plan approved under such Act, if such kickback, rebate, or bribe is made in connection with the furnishing of such items or services or the making or receipt of such payments. For purposes of this paragraph, a kickback includes a payment in consideration of the referral of a client, patient, or customer.

25) The entry made by the insurance company would be to record the cash payment of the hospital invoice. If the payment amount is less than the amount invoiced by the hospital (including invoice adjustments) and the hospital accepts the reduced payment amount as

full payment for the invoice, the insurance company must treat the amount discharged by the hospital as debt forgiveness income (Regs. 1.61-12(a)). In general, the debt forgiveness income would be recognized at the time that the creditor discharges the unpaid amount of the invoice.

26) The entry made would be to record the debt to the hospital equal to the amount invoiced by the hospital. The invoice from the hospital would be a deductible trade or business expense of the insurance company (Code Section 162(a)). The time at which the invoice would be deductible by the insurance company would be the taxable year in which (a) all the events have occurred which fix the fact of the liability; (b) the amount can be determined with reasonable accuracy; and (c) economic performance has occurred. Since all the above factors would be met upon receipt of the invoice by the insurance company, the expense would be deductible at the same time that the hospital invoice is recorded (Code Section 461(h)).

27) As to the amount on the bill: A prior or contemporaneous extrinsic agreement as to the amount to be paid is ineffective to vary the express terms of the instrument. In the case of Payne v. Nicholson, supra, the Supreme Court of Florida, in discussing whether oral testimony in support of a claimed set-off constituted an attempt to alter or vary the terms of the note, stated: "As regards a promissory note, an extrinsic agreement as to the mode of payment, or the amount of payment, must be ineffective, since the parties have expressly dealt with those matters in the instrument; but an agreement to concede a credit or counterclaim, as offsetting the obligation of the instrument, would be a separate transaction, not dealt with in the instrument, and valid." Wigmore on Evidence, § 2444; Bennett v. Tillmon, 18 Mont. 28, 44 P. 80; Buckeye Cotton Oil Co. v. Malone 33 Ga.App. 519, 126 S.E. 913; John Lucas & Co. v. Bradley, 4 Cir., 246 F. 693· Roe v. Bank of Versailles, 167 Mo. 406, 67 S.W. 303; Branch v. Wilson, 12 Fla. 543.

28) "Evidence of a parole agreement, made at the time of the execution of notes, that the maker should have the right to offset an account then existing in his favor, is not a variance from the contract embodied in the notes. 'Bennett v. Tillmon, supra'".

29) Internal Revenue Code (IRC) section 451 provides rules for determining the taxable year of inclusion for items of gross income. Section 1.451-1(a) of the Income Tax Regulations provides that under an accrual method of accounting, income is includible in gross income in the taxable year in which the "all events" test is met. The two-prong all events test is met when (1) all the events have occurred that fix the right to receive the income, and (2) the amount thereof can be determined with reasonable accuracy. Under the first prong of the all events test, a fixed right to receive income occurs when (1) the required performance occurs, (2) payment is due, or (3) payment is made, whichever happens first. See Rev. Rul. 74-607, 1974-2 C.B. 149. When an amount of income is properly accrued on the basis of a reasonable estimate and the exact amount is subsequently determined, the difference, if any, shall be taken into account for the taxable year in which such determination is made.

30) The Patient Protection and Affordable Care Act (Public Law 111-148) was signed into law on March 23, 2010 and was followed by the Health Care and Education Reconciliation Act of 2010 on March 30. This will ensure that all Americans have access to good quality, affordable health care while containing costs of treatment. The Affordable Care Act contains over a thousand pages of reforms to the insurance industry and the health care industry in order to cut healthcare costs and to provide affordable health insurance to all Americans. In order to provide affordable health care, the Internal Revenue Service has hired an additional 50,000 health care auditors.

31) During the first twenty years of the Medicare/Medicaid Programs, national health care costs grew from 6.5% of the Gross Domestic Product (GDP) to 8% of GDP. During this period, the standard charge and the customary charge were the same amounts and the health care providers gave no discounts. The hospitals were reimbursed for only the costs of treating beneficiaries of the Medicare/Medicaid Programs. The methodology identified all costs for all patients, and then the costs were apportioned between all the private-pay patients and the government beneficiaries, using the standard charge and the customary charges. Then, due to the rising costs of national health care, Congress changed to the Prospective Payment System, whereby the hospitals were paid a fixed fee for each Diagnostic Related Group (DRG). The fees for each DRG were increased annually through the measurements of a basket of financial indicators, which included the changes in the "customary charges" listed on the beneficiaries' bills.

32) During the last thirty years, under the Prospective Payment System, national health care costs grew from 8% of GDP to 18% of GDP. During this period, the hospitals gave what came to be known in the industry as "secret discounts" to the health insurance companies. However, the hospitals called these discounts "trade secrets", so that the discounts would not be disclosed to the public. The health care hospitals and insurance companies then began to use the non-standard accounting procedure on the private side of the business, utilizing the "Contract Adjustment Account" to hide their indiscretions. Moreover. the insurance companies pushed on the American public the insurance policies creating HMOs and PPOs, which contained many restraints of trade, eliminating their members' right to choose their health care provider, with promises these insurance products would lower our medical costs. The hospitals are now writing off 85% of the private-pay and insured patients' billed revenue. This 85% write off is actually taxable billed revenue.

33) There exists a clear intention on the part of the hospitals and the insurance companies to defraud the government by their INTENTIONAL OMISSION to include in their returns that huge amounts of kickbacks (income) were condoned and purposely not included in said returns. This intentional omission shall devoid the tax exemption granted by the government to the aforementioned entities. Consequently, all of the condoned amounts or kickbacks must be subjected to tax.

34) The IRS cannot say they are unable to collect taxes because of the principle of estoppel. The principle of equitable estoppels cannot be applied to deprive the public of the protection of a statute because of the mistaken action or lack of action on the part of

public officials[il]l. Estoppel will not operate against the Government even by an affirmative undertaking on the part of an officer or agency of the United States to whom no administrative authority has been delegated to waive or surrender a public right.(United States v. Stewart (1940) 311 US 60, 85 L ed. 40, 61 S Ct 102.) It is also worthy to note that bills and receivables partake of the nature of promissory notes. (State v. Robinson, 57 Md. 486, 501; Miami Coal Co. v. Fox, 176 NE. **11,** 16, 203 Ind. 99.) Assumption of Indebtedness exists when person binds himself to pay a debt incurred by another. (Pawnee County Excise Board v. Kurn, 187 Old. 110, 101 P.2d 614, 618.)

35) The contract between the hospital and the patient creates the indebtedness. The contract between the hospital and the health insurance company make the hospital the customer, the purchaser of services from the health insurance company. The consideration paid by the provider is the forgiveness of debt owed by the insurance company's member. The consideration provided by the insurance company, the seller, is the financial coercion of its members to use the medical services of the provider and boycott other health care providers. The contract between the health care provider and the health insurance company is for illegal purposes. It calls for a restraint of trade and a boycott of other health care providers. It calls for the price fixing of a third party, the co-payment of the insured member of the HMO. The forgiveness of debt revenue is taxable revenue for the hospital and the insurance company. Both must pay taxes, whether or not these corporations are for-profit, not-for-profit or tax exempt.

36) The hospitals, for their private-pay insured patients and the patients on the Medicare Plus plans, have been writing off six dollars for every dollar realized. Therefore, these write offs are subject to taxation, and both the hospitals and the insurance companies owe trillions of dollars to the American people. Our Tax Code mandates the Internal Revenue Service to collect these taxes or come to some fair settlement with each non-compliant taxpayer, whether the taxpayer is a private or public corporation, for-profit, not-for-profit, taxable or Tax exempt, and state entities.

37) Specifically, IRC 501, the ruling provision with regard to tax exemptions, appears to be self-enforcing. IRC 503 refers to IRC 501 in every case where an exemption is granted or denied -- thus, IRC 501 is the basis for all organizational tax-exempt status. IRC 501(a) provides that "An organization described in subsection (c) or (d) or section 401(a) shall be exempt from taxation under this subtitle **unless such exemption is denied under section 502 or 503."**

38) Moreover, Treas. Reg. 601.201(n)(6) provides authority to revoke 501(c) tax-exempt status, under the general administrative powers conferred on the IRS Commissioner by the Secretary of the Treasury, pursuant to IRC 7805(a). Treas. Reg. 601.201(n)(6) (which is extremely long), begins, "(i) An exemption ruling or determination letter may be revoked or modified by a ruling or determination letter addressed to the organization, or by a revenue ruling or other statement published in the Internal Revenue Bulletin. The revocation or modification may be **retroactive if the organization omitted or misstated a material fact,** operated in a manner materially different from that originally

represented, or **engaged in a prohibited transaction** of the type described in subdivision (vii) of this subparagraph. In any event, revocation or modification will ordinarily take effect no later than the time at which the organization received written notice that its exemption ruling of determination letter might be revoked or modified."

39) In the near future both the hospitals and the insurance companies will have to lower their charges by 85%. The hospital will have to determine the lowest priced, money actually received, to the lowest cost ratio of a **DRG** and then apply this ratio to all the **DRG's** to determine their charges. This methodology is required under the Social Security Law and makes sure there is no cost shifting among patients. The insurance companies will have to determine their premiums based on the actual revenues spent on health care, plus a reasonable administrative cost, close to the Medicare/Medicaid Programs administrative cost of three percent (3%). Both the hospitals and insurance companies will have to eliminate any restraint of trade agreements and return to open competition in the health care industry. If the industry does not change its methods of doing business, it will be taxed out of existence and the Federal Government will take over the Health Care Industry.

40) A word of caution, to anyone required to certify financial reports and tax returns. Wrongful endorsement and certification is seen as a malpractice and can cost you your license. You may also face legal action with fines and, at times, even imprisonment. To avoid this, ensure that you know the contracts used by these health care institutions and their legality. Study the returns thoroughly for such misuse of the "Contract Adjustment Account" and any other such misappropriations before certifying a return or financial report.

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Percentage Changes 1987 — 2011	
Hospital Gross Billing	1354%
Hospital Revenue	372%
Consumer Price Index	95%

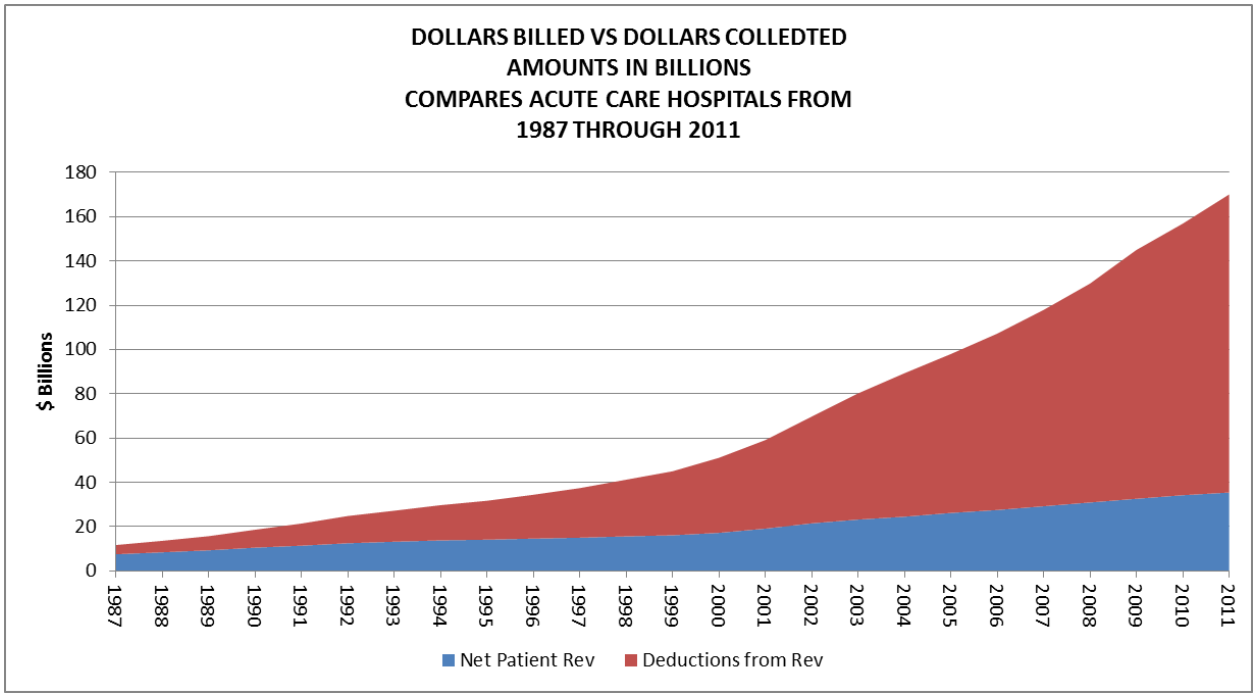

Exhibit G

For Lee Memorial Health System ("LMHS") facilities, including but not limited to: Lee Physician Group, Lee Convenient Care, Lee Memorial Hospital, HealthParic Medical Center, Gulf Coast Medical Center, and Cape Memorial Hospital, Inc. dIbla Cape Coral Hospital.

NOTICE OF LIMITED LIABILITY

j, **ON BEHALF OF MYSELF, MY CHILD, AND/OR MY WARD, ACKNOWLEDGE I HAVE BEEN INFORMED THAT:** Medical care and treatment that I receive *at* a LMHS facility may be provided by LMHS-employed physicians, surgeons, nurse-midwives, physician assistants, nurse practitioners, and other individuals (all herein "Providers") who are employees or agents of Lee Memorial Health System ("LMHS"). I understand that those Providers that are LMHS employees and agents are under LMHS's exclusive supervision and control and that the liability for the acts or omissions of these LMHS Providers is limited to $100,000 per claim or judgment by any one person and to $200,000 for all claims or judgments arising out of the same incident or occurrence (see Section 768.28, Florida Statutes).

I further acknowledge that I may receive medical care and treatment from other independent health care contractors, including, but not limited to, my private practicing physician, radiologists, anesthesiologists, emergency care providers, pathologists, and perfusionists, who are neither the employees nor agents of LMHS. I recognize and agree that LMHS is NOT responsible for the acts or omissions of these independent contractors.

Patient/Legal Representative: _____ Date:_____ Witness_____

1. **Assignment of Benefits.** I hereby assign to LMHS payment from all third party prayers* with whom I have coverage or from whom benefits are or may become payable to me, for the charges of hospital and health care services I receive for, related to, or connected with my admission or treatment (past, present, or future). I agree to be personally responsible for payment of any hospital or health care services that are not covered by my third party payors*, including, but not limited to, non-covered or out-of-network services, deductibles, coinsurance, and/or co-payments. I also assign payment of any available insurance benefits to the physician(s) who provide me treatment at LMHS.
2. **Release of Information.** I acknowledge that LMHS is authorized under Florida state and U.S. federal Law to release copies of my billing and medical records, to ensure payment for hospital and health care services I receive for, related to, or connected with my admission or treatment (past, present, or future), to secure additional treatment if needed, and to otherwise facilitate health care operations related thereto, to the following persons or entities: any health care facility or affiliated provider; my referring or treating providers; ambulance and similar transportation providers; the Guarantor on my accounts and any third party payors* or their agents; any Florida state or Federal regulatory entities and accrediting organizations; the Social Security Administration, the Florida Department of Children and Family Services, and other similar entities. This specifically includes health information concerning psychological conditions, psychiatric conditions, and/or infectious *diseases* including, but not limited to, blood born diseases such as Hepatitis, Human Immunodeficiency Virus (HIV), and Acquired Immune Deficiency Syndrome (AIDS). If my admission or treatment is due to a motor vehicle accident I authorize LMHS to obtain a copy of my "crash report" required by Florida Statutes, to facilitate third party payment.
3. **LMHS Financial Practices.** I understand and agree that
   (a) LMHS's charges for hospital services are set out in the hospital's price list (the "Charge Master"), the relevant portions of which I may examine during regular business hours at the Financial Services office located at 224 Santa Barbara Blvd, Cape Coral, 33991, and LMHS reserves the right to review and change the prices set out in the Charge Master;
   (b) LMHS's account of my hospital charges is an "open account" that will include all of my hospital charges and all payments, whenever such charges or payments are made, as part of a single transaction giving rise to a single liability and LMHS may prepare bills for amounts up to and including the account's total amount due on a regular basis;
   (c) The amount of hospital charges that I am obligated to pay may differ from the amounts other patients are obligated to pay based upon each patient's private insurance coverage, Medicare/Medicaid coverage, and/or ability to pay;
   (d) I may request and will be provided with information about LMHS's charity care programs, for which I may qualify if i meet the relevant income tests and otherwise lack the ability to pay all the hospital's charges;
   (e) As a courtesy, LMHS may bill third parties, including my insurance company, but it is not obligated to do so. Regardless, I agree that, except where prohibited by law, I agree to pay those charges reflected on LMHS's uniform billing instruments (UB-04 or CMS-1500 forms) for services rendered to me at LMHS.
4. **Guarantor Agreement.** I hereby agree to the following:
   (a) I am responsible for paying the charges of all hospital and health care services Patient receives for, related to, or connected with the Patient's admission or treatment (past, present, or future), and same are due and payable at the time of discharge or discontinuation of treatment. The charges I agree to pay are those listed in LMHS's Charge Master in effect at the time the services were rendered and reflected on the Hospital's uniform billing instrument (UB-04 form);
   (b) Unless otherwise precluded by law or contract, if as a courtesy LMHS bills third party payors*. LMHS may demand payment in full of any balance due, at any time;
   (c) I understand that I will be billed **separately** by LMHS for services rendered by it (including LMHS-employed Providers) and by any independent contractor who provides services to me (for example, my private practicing physician, anesthesiology, radiology, pathology or laboratory services);
   (d) any overdue accounts may be referred to a collection agency or attorney, in which case I agree to pay attorney's fees, court costs, and/or collection agency fees associated with the collection process;
   (e) each of the undersigned agree to LMHS inquiring into his/her credit history in conformity with legitimate business needs and applicable laws, rules and regulations and further agrees that the hospital may, with or without notice, assign, transfer and convey to any agency or attorney its right title and interest in and to any balance due after the patient's discharge;
   {f) I authorize LMHS to apply non-insurance payments received that exceed the amount necessary to pay LMHS' charges for this hospitalization to the payment of any unpaid LMHS bill of myself or of my immediate family.
5. **Lien on Third Party Liability Proceeds. If** my admission or treatment is due to an accident or injury, LMHS shall have a lien upon the proceeds of any cause of action, suit, claim, counterclaim, or demand accruing to me or my legal representative as a result of such accident or injury, in order to recover payment for all charges of hospital and health care services I receive for, related to, or connected with such accident or injury effective as of the date treatment was first provided. I understand and acknowledge that LMHS also expressly reserves the right to secure payment of some or all of its charges by recording a statutory hospital lien. In such event, LMHS may, in its sole and absolute discretion, seek recovery for payment of its charges from the proceeds of any payment made by third parties on account of the accident, giving rise to the treatment provided by LMHS. I understand and acknowledge that the amount demanded by LMHS from third party source(s) may and likely will exceed the amount that would otherwise be payable under my health insurance, HMO, or health plan coverage.
6. **Faith.** I give permission to LMHS clergy staff to contact my faith group representative to notify them of this admission ❑ YES CI NO LI NA
7. **Valuables Release.** I acknowledge that I have been given the opportunity to deposit valuables and money with LMHS for safekeeping. I understand that LMHS assumes no responsibility for personal property (including, but not limited to, valuables, money, cell phones, beepers, shoes, or clothing) retained by me, and I hereby release LMHS, its directors, officers and employees, from any and all liability for loss of such personal property and I will personally assume all loss, cost, or expense incurred as a result of any such loss.
8. **Students.** LMHS supports the training and eduCation of health care professionals and technicians and provides opportunities for practical learning experiences. I acknowledge that I may be cared for by students or other health care personnel in supervised training programs. I acknowledge that I can advise my nurse or physician if I choose not to have such individuals participate in my care.
9. **Generic Medications.** Medications used at LMHS are selected by the Pharmacy and Therapeutics Committee of the LMHS Medical Staff. Whenever possible, generic medications are administered, rather than "brand names' products. For my convenience and for ease of understanding what medications I am receiving, they may be referred to by their brand names, even though the generic equivalent is what is actually used.
10. **Recycling.** In strict accordance with U.S. Food and Drug Administration standards, LMHS sends some disposable medical and surgical supplies to be processed and sterilized for re-use. This is a safe, environmentally sound, cost-saving measure.

'Third party *payors include, but are not limited to, coverage available from: Medicare, Medicaid,* Tri-care, *or governmental programs; health, accident, automobile, or other insurance; workers' compensation; HMOs;* self-insured *employers; and any sponsors who may contribute payment for services.*

I, the undersigned, as the patient, or the guardian, spouse, guarantor or agent of the patient, hereby certify I have read, and fully and completely understand this Conditions of Services and I have signed this Conditions of Services knowingly, freely, voluntarily and agree to be bound by its terms. I have received no promises, assurances, or guarantees from anyone as to the results that may be obtained by any treatment or services.

Patient/Legal Representative: _____ Date: _____ Time: _____

CI **Patient is medically unable to sign Q Patient refused to sign**

Guarantor:_____ Date: _____ Time: _____

(FINANCIALLY RESPONSIBLE PERSON)

HOSPITAL PARTICIPATION AGREEMENT
BETWEEN
United Healthcare of Florida, Inc.
And
Hospital Board of Directors of Lee County d/b/a
Lee Memorial Hospital System

WIC

THIS AGREEMENT, effective 1, 1999 ("Effective Date"), is between United HealthCare of Florida, Inc. ("Plan") and the Hospital Board of Directors of Lee County dibia Lee Memorial Hospital System ("Hospital") and sets forth the terms and conditions under which Hospital (Exhibit 1) shall participate in one or more networks of providers developed by Plan to render health care services to Members, as defined in this Agreement. This Agreement shall apply to the Gulf Coast Region whose service area may change from time-to-time. On the Effective Date, this Agreement supersedes and replaces in the Gulf Coast Region any existing agreements between the parties related to the provision of health care services to Members. This Agreement also supersedes and replaces any existing agreements between Hospital and the following entities to the extent such agreements relate to the provision of health care services to Members, and to the extent such entities sponsor, issue, or:administer a Benefit Contract, as defined in this Agreement CAC - United HealthCare Plans of Florida, Inc., CAC Ramsay Health Plans, Inc., United HealthCare Plans of Florida, Inc., The MetreHealth Insurance Company, The Travelers Insurance Company, Metropolitan Life Insurance Company, and United Health and Life Insurance Company.

SECTION 1
Definitions

Admission: Admittance of a Member to a licensed acute hospital bed, excluding an observation bed. for a period of not less than 24 hours unless Payor authorizes otherwise.

Benefit Contract: Benefit plan that includes health care coverage, is sponsored, issued, or administered by Payor and contains the terms and conditions of a Member's coverage.

Customary Charge: Fee for health care services charged by Hospital that does not exceed the fee Hospital would charge any other person regardless of whether the person is a Member.

Health Services: Health care services and supplies covered by the Member's Benefit Contract.

Hospital-Based Provider: Health care profeSsionals who are employed by or under contract with Hospital to render Health Services to Members. Hospital-Based Providers include, but are not limited to, emergency room physicians, pathologists, radiologists, anesthesiologists, certified registered nurse anesthetists, and intensivists.

Member: individual who is properly covered under a Benefit Contract.

Member Expenses: Any amounts that are the Member's responsibility to pay Hospital in accordance with the Member's Benefit Contract, including copayments, coinsurance, and deductibles.

Participating Provider: Health care professional or facility, including Hospital, that has a written participation agreement in effect with Plan, directly or through another entity, to provide Health Services to selected groups of Members.

Payer: Entity or person authorized by Plan to access one or more networks of Participating Providers developed by Plan and that has the financial responsibility for payment of Health Services covered by a Benefit Contract_

Hospital shalt provide Health Services to Members covered under the Benefit Contract types described in Exhibit 2, which may be modified from time to time by Plan upon written notice to Hospital, and which includes, but is not limited to, Benefit Contracts that offer a network of Participating Providers.

When Benefit Contracts offer a network of Participating Providers the product name will appear on the Member's identification card and the Members will receive a provider directory listing all Participating Providers. Members covered under these Benefit Contract types are incented to receive services from Participating Providers. Such incentives may include, but are not limited to, a higher level of coverage and/or the potential reduction or elimination of Member Expenses.

SECTION 3
Duty's of Hospital

3.1 Member Status_ To determine whether a individual is a Member and, therefore, entitled to receive Health Services, Hospital shall ask the individ al to present his/her identification card, which shall be provided to all Members by Payors. In additio , Hospital may contact Plan to obtain Plan's most current information on the individual as a Member. owever, Hospital acknowledges that such information is subject to change retroactively if Plan doe not receive proper and timely notification regarding termination of a Member's coverage, as a resu t of the Member's final decision regarding continuation of coverage pursuant to state and federal laws, o if eligibility information Plan *receives* on the individual is later proven to be false. If Hospital provid health care services to an individual, and it is later determined the individual was not a Member t the time the health care services were provided, those services shall not be eligible for payment un er this Agreement. Hospital may then directly bill the responsible party for such services.

3.2 Provision of **Health Services.** Hospital s all provide Health Services to all Members as Hospital's staff and facilities permit and shall accept Me bets as new patients on the same basis as Hospital is accepting non-Members as new patients without regard to source of payment, race, religion, gender, color, national origin, age, or physical or mental health status, or on any other basis deemed unlawful under federal, state, or local law. Hospital also agrees to observe, protect, and promote the rights of Members as patients and to provide Members equal treatment with other patients. At all times, Hospital shall use best efforts to require employed or subcontracted health care professionals and facilities to comply with the protocols and requirements of Plan and the requirements of all applicable regulatory authorities. Such requirements include, but are not limited to, not billing Members for any amounts except Member Expenses and charges for services not covered under the Member's Benefit Contract. Plan shall make its best effort to provide Hospital with prior written notice of any changes in its protocols.

3.3 Utilization Management, Quality Improvement, and Other Plan or Payor Programs. Hospital shall cooperate with all credentiating and recredentlaling processes and all utilization management, quality improvement, peer review, Member grievance, on site concurrent review, or other similar Plan programs.

3.4 Protocols. Hospital shall make its best effort to comply with protocols of Plan, including, but not limited to the following:

1. Refer Members only to other Participating Providers unless otherwise authorized by Plan or unless medically inappropriate.
2. Be bound by Plan's provider manual and credentialing plan, as modified from time-to-time by Plan.
3. Obtain prior authorization for certain Health Services as defined by Plan.
4. Follow approved billing procedures of Plan, as set forth in Section 4.2 below or in the provider manual.

J. nospitai snail comply with the following Admission requirements:

a. Notify Plan by telephone at least 48 hours prior to a scheduled Admission of a Member.

b. Notify Plan immediately if a Member is admitted to Hospital for an emergency or for observation.

c. If applicable, notify Payor's psychiatric designee of all mental health or substance abuse Admissions in accordance with the above time frames.

Repeated failure to comply with the above may result in denial of payment to Hospital and/or termination of this Agreement. If any payment to Hospital is denied due to Hospital's repeated failure to comply with the above, Hospital shall not bill the Member for the denied amounts.

3.5 Hospital-Based Providers. Hospital shall provide Plan with the criteria utilized by Hospital to select and credential employed or subcontracted health care professionals and facilities, including, but not limited to, Hospital-Based Providers. Plan shall have the right to audit such criteria upon reasonable advance written notice to Hospital.

SECTION 4
Payment Provisions

4.1 Payment. For the provision of Health Services to a Member, Payor shall pay Hospital the applicable amounts set forth in the attached appendices. The obligation for payment under this Agreement for Health Services rendered to a Member is solely that of Payor. Plan shall make its best effort to require Payors to comply with the terms of its participation agreements with its Participating Providers. Payor shall make payment to Hospital within 35 days following Plan's receipt of the claim information set forth in Section 4.2. If Payor denies or contests a claim, Plan shall notify Hospital within 35 days following Plan's receipt of the claim and shall identify the contested portion of the claim and the specific reason for contesting or denying the claim. Plan shall notify Hospital of its need for additional information within 35 days following Plan's receipt of a claim. Plan shall make or deny payment to Hospital within 45 days following Plan's receipt of all requested information. Under no circumstances shall Payor pay or deny a claim more than 120 days following Plan's receipt of the claim. Payment of a claim is considered made on the date the payment was received or electronically transferred or otherwise delivered. An overdue payment of a claim bears simple interest at the rate of ten percent per year.

Except as provided herein, Hospital shall accept as payment in full for Health Services rendered to Members such amounts as are paid by Payor pursuant to this Agreement and shall not bill Members for non-covered charges which result from Payor's reimbursement methodologies. Except as provided herein, in no event shall Hospital bill a Member for the difference between Customary Charges and the amount Hospital has agreed to accept as full reimbursement under this Agreement. Hospital may collect Member Expenses from the Member. If Payor denies payment for services rendered by Hospital on grounds that the services are not medically necessary, as defined in the Member's Benefit Contract, or charges for services not covered under the Member's Benefit Contract, Hospital shall not collect payment from the Member for services unless Hospital first obtains the Member's written consent.

4.2 Submission of Claims. Hospital shall submit claims for Health Services to Plan in a manner and format set forth herein, which may be an electronic format. All information necessary to process the claims must be received by Plan no more than 90 days from the date of discharge and 90 days from the date all outpatient Health Services are rendered, Hospital agrees that claims received after this time period may be rejected for payment, at Plan's and/or Payor's discretion. An exception to the 90 day claims submission deadline will be made if, as soon as possible but within the 90 days, Hospital gives Plan written notice that the deadline can not be met due to coordination of benefits with another payor.

Hospital shall submit claims using current HCFA 1500 or UB92 forms, whichever is appropriate, with applicable coding including, but not limited to, ICD9, CPT, Revenue, and HCPCS coding. Hospital shall include in a claim the Member number, Customary Charges for the Health Services rendered to a Member during a single instance of service, as applicable, Hospital's federal tax identification number,

- and/or other identifiers requested by Plan. Hospital shall not bill the Member for Health Services if Hospital fails to submit claims in accordance with the above provisions.

Payor shall have the right to make, and Hospital shall have the right to request, corrective adjustments to a previous payment provided, however, that Payor shall have no obligation to pay and Hospital shall have no obligation to refund, additional amounts after 12 months from the date the initial claim was paid, unless Plan determines fraud may be involved.

4.3 Coordination of Benefits. Hospital shall be paid in accordance with Payor's coordination of benefits rules to the extent not inconsistent with Florida law.

4.4 Financial Responsibility. Plan shall notify Hospital in writing if Plan determines that a Payor has failed to maintain its responsibility to pay for services rendered. Any services which have been rendered by Hospital prior to and after such notification, and which were not paid for by Payor, shall be considered ineligible for reimbursement under this Agreement, and Hospital may bill the Member directly for such services.

4.5 Continuation of Benefits and Member Protection Provision. This provision applies in instances where required by applicable statutes and regulations:

Hospital agrees that in the event of Payor's insolvency or other cessation of operations, benefits to Members will continue and Hospital wilt continue to provide Health Services to Members through the period for which premium has been paid and benefits to Members confined in an inpatient facility on the date of Payor's insolvency or other cessation of operations will continue and Hospital will continue to provide Health Services to Members until their discharge.

This provision supersedes and replaces the financial responsibility section when Plan is the Payor or when required pursuant to applicable statutes and regulations:

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In no event, including, but not limited to, non-payment by Payor for Health Services rendered to Members by Hospital, insolvency of Payor, or breach by Plan of any term or condition of this Agreement, shall Hospital bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against any Member or persons acting on behalf of the Member for Health Services eligible for reimbursement under this Agreement; provided, however, that Hospital may collect from the Member any Member Expenses or charges for services not covered under the Members Benefit Contract.

The provisions of this section shall (1) apply to all Health Services rendered while this Agreement is in force; (2) with respect to Health Services rendered while this Agreement is in force, survive the termination of this Agreement regardless of the cause of termination; (3) be construed to be for the benefit of the Members; and (4) supersede any oral or written agreement, existing or subsequently entered into, between Hospital and a Member or person acting on a Members behalf, that requires the Member to pay for such Health Services.

4.6 Exhaustion of Coverage. If a Member's health care coverage under his/her Benefit Contract is exhausted during an Admission and no other health care coverage for that Member is available, Hospital may collect from the Member charges for services rendered during the Admission which are no longer covered.

SECTION 5
Liability of Parties, Laws, Regulations, and Licenses

5.1 Plan's Responsibility for Damages. Plan shall be responsible for any and all damages, claims, liabilities or judgments which may arise as a result of its own negligence or intentional wrongdoing. Any costs for damages, claims, liabilities or judgments incurred at any time by one party as a result of Plan's negligence or intentional wrongdoing shall be paid for or reimbursed by Plan.

5.2 Hospital's Responsibility for Damages. Hospital, as a state agency or subdivision, as defined in Florida Stat. § 768.28, agrees to be fully responsible to the limits set forth in Florida Stat. § 768.28 for its negligent or wrongful acts or omissions and agrees to be liable to the limits set forth in Florida Stat. § 768.28 for any damages proximately caused by said omissions or acts. Nothing herein shall be construed to create a right of indemnification or be a waiver of sovereign immunity by Hospital if sovereign immunity applies_

5.3 Hospital's Insurance. Hospital shall maintain a self-insurance fund which provides for liability coverage to the extent of the statutory waiver of sovereign immunity under Florida Stat. § 768.28. Hospital shall ensure that all health care professionals employed or under contract with Hospital are covered by the appropriate employing agency to the extent of the statutory waiver of sovereign immunity under Florida Stat. § 768.28. Hospital shall require each non-employee physician to procure and maintain, at physician's sole expense, medical malpractice insurance in the amounts of $250,000 per occurrence and $750,000 aggregate, and comprehensive general and/or umbrella liability insurance in the amount of $250,000 per occurrence and aggregate. Hospital shall also require each non-employee physician require that all health care professionals employed by or under contract with the non-employee physician to render Health Services to Members procure and maintain malpractice insurance, unless they are covered under the physician's insurance policies. The non-employee physician's and other health care professionals' medical malpractice insurance shall ***be*** either occurrence or claims made with an extended period reporting option under such terms and conditions as may be reasonably required by Plan. Prior to the Effective Date of this Agreement and at each policy renewal thereafter, each non-employee physician shall submit to Plan written evidence of insurance coverage.

5.4 Laws, Regulations, and Licenses. Hospital shall maintain all federal, state, and local licenses, certifications, and permits, without material restriction, which are required to provide health care services according to the laws of the jurisdiction in which Health Services are provided and shall comply with all applicable statutes and regulations Hospital shall also require that all health care professionals employed by or under contract with Hospital to render Health Services to Members comply with this provision.

5.5 Plan's Insurance. Plan, at its sole cost and expense, shall procure and maintain comprehensive general liability, professional liability and other necessary insurances to insure Plan and its employees, acting within the scope of their duties, against claims for damages arising by reason of personal injury or wrongful death occasioned directly or indirectly by Plan or by its employees in connection with the performance of Plan's responsibilities under this Agreement.

SECTION 6
Notices

Hospital shall notify Plan within ten days of knowledge of the following:

1. Changes in liability insurance carriers, termination of, renewal of, or any other material changes in liability insurance, including reduction of limits, erosion of aggregate, changes in retention or non-payment of premium, or any material adverse change in Hospital's financial status which affects its self-insurance.
2. Action which results in the Suspension, revocation, condition, limitation, qualification, or other material restriction on Hospital's or any Hospital-Based Provider's licenses, certifications, or permits by any government under which Hospital or the Hospital-Based Provider is authorized to provide health care services.
3. Change in name, ownership, or federal tax identification number.
4. Action taken by Hospital to suspend, revoke, or allow the voluntary relinquishment of the medical staff membership or clinical privileges of any Hospital-Based Provider or Participating Provider, unless the action taken will last 30 days or less.
5. Conduct which creates an imminent danger to a Member.

Unless otherwise specified in- this Agreement, any notice or other communication requited or permitted shall be in writing. All written notices or communication shall be deemed to have been given when

delivered in person; or, if delivered by first-class United States mail, on the date mailed, proper postage prepaid and properly addressed to the appropriate party at the address set forth at the signature portion of this Agreement or to another more recent address of which the sending party has received written notice. The parties shall provide each other with proper addresses of all designees that should receive certain notices or communication instead of that party.

SECTION 7
Records

7.1 Confidentiality of Records. Plan and Hospital shall maintain the confidentiality of all Member records in accordance with any applicable statutes and regulations.

7.2 Maintenance of and Plan Access to Records. Hos financial lei shall maintain adequate medical and records related to Health Services rendered by H monitor and pital under this Agreement. In order to evaluate the quality of care, conduct evaluations retrospective and audits, determine on a concurrent or basis the necessity of and appropriateness of perform its ealth Services provided to Members, and utilization management and quality improvement information ctivities, Plan shall have access to such and records, including claims records, within 14 except that, days from the date the *request* is made, e in the case of an audit by Plan such access shall make its best given at the time of the audit. Plan shall of effort to provide Hospital with reasonable notice shall provide an audit. if requested by Plan, Hospital the copies of such records at a charge for by page a Florida law. usual and customary rate permitted by ble Unless a longer time period is required by applica access to statutes or regulations, Plan shall have and the right to audit information and records durig the term of this Agreement and for five years following its termination or longer if records are under r̊view or audit, until such review or audit is completed. It is Hospital's responsibility to obtain any Memb consent required in order to provide Plan with requested information and records or copies of records.

7.3 Government and Accrediting Agency Access to ecords. The federal, state, and local d to, government, or accrediting agencies including, but not limit. the National Committee for Quality ave Assurance, and any of their authorized representatives shall access to, and Plan and Hospital are nd authorized to release, in accordance with applicable statutes regulations, all information and records or copies of such, within the possession of Plan or Hos ital, which are pertinent to and involve transactions related to this Agreement. Such transactions include, but are not limited to, compliance with accreditation standards, statutes, or regulations, assessment & the quality of care, and investigation of a Member grievance or complaint.

SECTION 8
Term and Terminati n

8.1 Term. This Agreement shall begin on the Effective Date, hail remain in effect for one year, and shall automatically renew for successive one-year terms until termin ted as provided below.

8.2 Termination. This Agreement may be terminated as folio s:

1. by mutual agreement of Plan and Hospital.
2. by either party upon 120 days prior written notice to th other party.
3. by either party, in the event of a breach of this ent by the other party, upon 30 days prior Agree written notice to the other party.
4. by Plan, immediately due to Hospital's loss or suspen ion of licensure, imposition of sanctions, or certification or loss of insurance or failure to maintain financial reserves sufficient to provide the level of self-insurance required under this Agreement.
5. by- Plan immediately upon written notice to ue to conduct which creates an imminent Hospital danger to a Member.

8.3 Regulatory Termination. In addition to the above, th e following shall apply with respect to the arrangement between Plan and Hospital:

1. f his Agreement may be terminated immediately upon issuance of an order by the Florida Department of Insurance (DOI").
   Nonpayment by Payor shall not *be* a valid reason for avoiding any required notice period for termination of this Agreement_
3. In addition to any prior notice Hospital and Plan are required to provide pursuant to this section, Hospital and Plan shall also give the same written notice of such termination to the DOI.

8.4 Information to Members. Hospital acknowledges the right of Plan to inform ¯Members of Hospital's termination and agrees to cooperate with Plan in deciding on the form of such notification. In addition to any prior notice Hospital and Plan are required to provide pursuant to this section, Hospital and Plan shall also give at least 60 days prior written notice of such termination to the DOI, when required by law.

8.5 Obligations Upon Termination. Upon the termination of this Agreement, the rights and obligations of the parties shall cease, except as otherwise provided by this Agreement. When medically necessary, Hospital will continue to provide Health Services to Members for up to 60 days if the Member has a life-threatening condition or a disabling and degenerative condition or until completion of postpartum care if the Member is in the third trimester of pregnancy. For such continued care, Plan and Hospital shall be bound by the terms of this Agreement. Plan shall pay Hospital for Health Services rendered after this 60-day period at HOspital's Customary Charges.

SECTION 9
Miscellaneous

9.1 Amendment. This Agreement may be amended only in writing and the amendment must be executed by all parties; provided, however, that Plan may amend this Agreement to comply with the requirements of state and federal regulatory authorities, and shall give written notice to Hospital of such amendment and its effective date. Unless such regulatory authorities direct otherwise, the signature of Hospital will not be required.

9.2 Assignment. Plan may assign all or any of its rights and responsibilities under this Agreement to any entity controlling, controlled by, or under common control with Plan. Hospital may assign any of its rights and responsibilities under this Agreement to any person or entity only upon the prior written consent of Plan, which consent shall not be unreasonably withheld.

9.3 Administrative Responsibilities. Plan may delegate certain administrative responsibilities under this Agreement to another entity, including, but not limited to, Payor or its designee. In addition, certain Payor responsibilities may actually be performed by its designee_

9A Relationship Between Plan and Hospital. The relationship between Plan and Hospital is solely that of independent contractors and nothing in this Agreement or otherwise shall be construed or deemed to create any other relationship, including one of employment, agency, or joint venture.

9.5 Name, Symbol, and Service Mark. During the term of this Agreement Hospital, Plan, and Payor shall have the right to use each other's name solely to make public reference to Hospital as a Participating Provider. Hospital, Plan, and Payor shall not otherwise use each other's name, symbol, or service mark without prior written approval_

9.6 Confidentiality. Neither party shall disclose to third parties any confidential or proprietary business information which it .receives from the other party, including, but not limited to, financial statements, business plans, protocols, and programs; except that Hospital may disclose information to a Member relating to- the Member's treatment plan and the payment methodology, but not specific rates and Plan may disclose certain terms to Payors or designees that need the information to process claims or administer a Benefit Contract, and may file the form of this Agreement with any federal or state regulatory entity as may *be* required by applicable law.

9.7 Communication. Plan encourages Hospital to discuss with Members treatment options and their associated risks and benefits, regardless of whether the treatment is covered under the Member's Benefit Contract. Nothing in this Agreement is intended to interfere with Hospital's relationship with Members as patients of Hospital or with Plan's ability to administer its quality improvement, utilization management, and credentialing programs.

9.8 Appendices. Additional and/or alternative provisions, if any, related to certain Health Services rendered by Hospital to Members covered by certain Benefit Contracts are set forth in the appendices_

9.9 Entire Agreement. This Agreement constitutes the entire agreement between the parties in regard to its subject matter.

9.10 Governing Law. This Agreement shall be governed by and construed in accordance with applicable Florida law and ERISA.

9.11 Medicare Members. If a Medicare Appendix is attached to this Agreement, Hospital agrees to provide Health Services to Members and to cooperate with Plan in providing any information and/or notices to Members who are enrolled in a Benefit Contract for Medicare beneficiaries. No Member Expenses shall be applied for Members enrolled in a Medicare HMO benefit program unless specified in the Benefit Contract. Hospital also understands that Plan's agreements with Participating Providers are subject to review and approval by the Health Care Financing Administration ("HCFA").

9.12 Limited Procedures. Plan shall notify Hospital in writing of any limitation, restriction, and/or condition placed upon Hospital with respect to the provision of specific Health Services to Members. Any additional and/or alternative provisions related to Health Services rendered by Hospital to Members covered by certain Benefit Contracts are set forth in the appendices.

9.13 Third-Party Beneficiary. Except as provided in Section 4.5 and except for any Payors, as defined in this Agreement, nothing in this Agreement shall create any rights or remedies in any third parties.

United HealthCare of Florida, Inc.
4350 West Cypress Street
Suite 908
Tampa, FL 33607

By: _____
Its: _____
Date: 3/23/99

Hospital Board of Directors of Lee County d/bIa Lee Memorial Hospital System
8250 College Parkway
Fort Myers, **FL 33919**

By: _____
Its: _____
Date: 3-a, 3-,

Incorporated by Reference Attachments:

X	Exhibit 'I - Participating Hospitals
X	Exhibit 2- Networks of participating Providers
X	All Payor Payment Appendix

tX111131t

CLAIMS PAYMENT ADDRESS:
Lee Memorial Health System
P.O. Box 2504
Fort Myers, FL 33902

INDICATE ALL OFFICES AND THE PROVIDER(S) WHO PROVIDE SERVICE AT EACH LOCATION:

CENTER NAME (if applicable) Cape Coral Hospital
ADDRESS P.O. Box 150010
Cape Coral, FL 33915

COUNT'? Lee
PHONE NUMBER 941-334-3950

TAX ID NUMBER 65-0666516

** Note: Tax ID for Cape Coral* ***is different from other facilities.***

CENTER NAME (if applicable) Lee Memorial Hospital
ADDRESS 2776 Cleveland Ave.
Fort Myers, FL 33908

COUNTY Lee
PHONE NUMBER 941-334-3950

TAX ID NUMBER 59-0714812

CENTER NAMEE. (if applicable) HealthPark Medical Center
ADDRESS 9981 HealthPark Circle
Fort Myers, FL 33908

COUNTY Lee
PHONE NUMBER 941-433-7799

TAX ID NUMBER 59-0714812

CENTER NAME (if applicable) The Children's Hospital
ADDRESS 9981 HealthPark Circle

COUNTY Lee
PHONE NUMBER 941-432-5437
TAX ID NUMBER 59-0714812

Fort Myers, FL 33908

CENTER NAME (if applicable)	Riverwalk Sports Medicine & Rehabilitation Clinic
ADDRESS	8350 Riverwalk Park Blvd., Ste. 2
	Fort Myers, FL 33919
COUNTY	Lee
PHONE NUMBER	941-432-0500
TAX ID NUMBER	59-0714812

EXHIBIT 2

Networks of Participating Providers

Hospital shall participate in the networks of Participating Providers established by Plan for the Benefit Contract types identified below:

- Benefit Contracts where Members are offered a network of Participating Providers and must select a Primary Physician. The Primary Physician coordinates the Member's care and approves the rendering of Health Services to Members by other Participating Providers. **An option for** this Benefit Contract allows the Member to receive Health Services from a Participating or non-Participating Provider without the approval of the Primary Physician.

- Benefit Contracts where Members are offered a network of Participating Providers but are not required to select a Primary Physician. The Member may receive Health Services from a Participating Provider of his or her choice. An option for this Benefit Contract allows the Member to receive Health Services from non-Participating Providers.

Hospital shall not participate in the following networks:

- Benefit Contracts where Members are not offered a network of Participating Providers from which they may receive Health Services.

- Benefit Contracts for Medicare Members.

- Benefit Contracts for Workers' Compensation benefit programs.

- Benefit Contracts for Managed Indemnity

All Payor Appendix
(United Healthcare Choice, Choice Plus, Select, Select Plus, PPO)

APPLICABILITY

Unless another appendix to this Agreement applies specifically to certain Members, the provisions of this appendix apply to Health Services rendered by Hospital to Members covered by Benefit Contracts sponsored, issued, or administered by all Payors.

SECTION 1
Additional Definitions

Observation: Appropriately authorized Health Services rendered to a Member on an outpatient or inpatient basis which are necessary to evaluate and oversee the Member's condition. Health Services related to Observation include, but are not limited to, the use of a bed and periodic monitoring by a health professional. Observation Health Services rendered on an outpatient basis are to determine the need for possible Admission of the Member. Observation Health Services rendered on an inpatient basis are limited to false labor.

Open Heart Surgical Procedure: Health Services rendered to a Member during an Admission, which require splitting of the sternum, including but not limited to, coronary artery bypass, heart valve/vessel repair and/or replacement, and repair of an aortic aneurysm.

Outpatient Surgical or Scopic Procedure: Health Services rendered by Hospital to Member which involve a surgical or scopic procedure performed.in an ambulatory surgical or outpatient unit of Hospital. Health Services related to an Outpatient Surgical or Scopic Procedure shall include, but not be limited to, professional fees billed by Hospital, preadmission testing, nursing care, diagnostic and therapeutic services, ancillary services, durable medical equipment, supplies, including, but not limited to, anesthesia supplies, medications, and facility costs_

Payment Rate: Percentage payment made to Hospital for Health Services rendered to a Member, which is calculated as a percentage of Customary Charges for Health Services.

Per Case **Payment: Payment made to Hospital for Health** Services rendered to a Member during an Admission, for Observation, or for an Outpatient Surgical or Scopic Procedure. Such payment shall be considered payment in full for all Health Services rendered to the Member during the Admission, Observation, or Outpatient Surgical or Scopic PrOcedure including, but not limited to, professional fees billed by Hospital, preadmission testing, nursing care, critical care, diagnostic and therapeutic services, ancillary services, durable medical equipment, supplies, medications, ambulance services, and room and board charges rendered, unless otherwise provided for in this Agreement.

Per **Diem Payment: Payment made to** Hospital for each day of an Admission of a Member. Such payment shall be considered payment in full for all Health Services rendered to the Member during each day of the Admission including, but not limited to, professional fees billed by Hospital, preadmission testing, nursing care, critical care, diagnostic and therapeutic services, ancillary services, durable medical equipment, supplies, medications, ambulance services, and room and board charges, unless otherwise provided for in this Agreement.

Per Visit Fee: Flat rate payment made to Hospital for all Health Services rendered to a Member during each outpatient encounter. Such payment shall be considered payment in full for all Health Services rendered to the Member including, but not limited to, professional fees billed by Hospital, nursing care, diagnostic and therapeutic services, durable medical equipment, supplies, medications, facility and ancillary services, and, if applicable, room and board charges.

Outpatient Surgical or Scopic Procedure performed. No additional payments for aoaitionai outpatient Surgical or Scopic Procedures performed shall be made.

2.6 Open Heart Surgical Procedure Following Outpatient Cardiac Catheter. If a Member is admitted to Hospital for an open heart surgical procedure within 72 hours of a cardiac catheter Outpatient Surgical or Scopic Procedure, the payment set forth in Sections 2.3 and 2.4 shall not apply, and Hospital shall be paid the payment for an open heart surgical procedure as set forth in Section 2.2 of this appendix, less any applicable Member Expenses.

SECTION 3
Miscellaneous Provisions

al All-Inclusive Rates. Ali rates are all inclusive unless specified otherwise in this appendix.

3.2 Hospital-Based Provider Charges. All charges for professional services provided by Hospital-Based Providers are paid in addition to the payments set forth in this appendix. if Hospital bills Plan for professional services provided by Hospital-Based Providers and Plan has a participation agreement with the Hospital-Based Providers, Plan shall reimburse Hospital for these professional services according to the terms of the participation agreement with the Hospital-Based Providers. If Plan does not have a participation agreement with the Hospital-Based Physicians, Hospital shall assist Plan in securing participation agreements with such providers. Hospital shall assist Plan in securing participation agreements with such providers.

3.3 Mental Health and/or Substance Abuse. Except as otherwise indicated in Section 2.2 of this appendix, mental health and/or substance abuse services shall not be eligible for payment under this Agreement.

3.4 Inpatient Stop-Loss Threshold, When Customary Charges for Health Services rendered during a single Admission exceed Hospital shall be paid a Payment Rate of 55% in lieu of the Per Diem Payments set forth in Section 2.2; provided, however that the amount Hospital is paid for each day of that Admission shall not **exceed** Hospital shall be responsible for identifying on each claim that this inpatient stop-loss threshold has been reached. For purposes of the inpatient stop-loss threshold payment calculation, Per Case Payments, as set forth in Section 2.2, shall be excluded.