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February 8, 2010

VIA ELECTRONIC MAIL
Mr. Roy J. Meidinger
14893 American Eagle Ct.
Fort Myers, Fl. 33912

Re: Lee Memorial Hospital, Inc., et al. ("LMHS")

Dear Mr. Meidinger:

Pursuant to your request, I wish to provide you the following letter with respect to the legal matter for which you engaged me. I have thoroughly reviewed the financial statements and tax filings of LMHS.

You selected me and my firm to assist you in this matter based upon my legal tax experience. As a reminder, I was employed as trial attorney with the IRS from 1990 to 2006. My duties also included providing legal advice to the IRS Over these sixteen years I was responsible for litigating hundreds of cases before the U.S. Tax Court. I also performed all tasks necessary for preparing an IRS administrative file for litigation, including further documenting the file, issuing subpoenas to witnesses, obtaining certified documents, and hiring experts in tax court cases, and ultimately litigating the cases on behalf of the IRS before the U.S. Tax Court. I feel I am well versed in IRS administrative procedure and have a command of the relevant sections of the Internal Revenue Code (IRC), Treasury Regulations, Revenue Rulings, Revenue Procedures, Internal Revenue Manual (IRM), Chief Counsel Directives Manual (CCDM), and other internal procedural guidelines of the IRS.

Prior to being employed by the IRS, I was licensed as a certified public accountant (CPA) and as an attorney (JD) on July 7, 1982 and May 5, 1984, respectively. From 1984 through 1990, I was employed at Ernst & Young, LLP, one of the "big-four" national accounting firms, where I was a manager in the tax department providing tax planning and tax compliance advice. During my career with the IRSI was also a Special Assistant to the U.S. Attorney representing the IRS in cases in other venues.

The facts pertaining to this case are that the LMHS is a not-for-profit entity incorporated in the State of Florida and tax exempt pursuant to IRC § 501(c)(3). Although LMHS is not

subject to taxation on revenue recognized during the normal course of its business, it must comply with the Internal Revenue Code in order to keep its tax exempt status. LMHS, as many medical services providers have done, has engaged in accounting manipulations resulting in the understatement of its income and the income of other taxpayers in which it is engaged in business.

LMHS is on the accrual method of accounting with respect to its books and records and must follow the Generally Accepted Accounting Practices (GAAP) for this accounting method.

The normal accounting practices of the LMHS results in a number of tax consequences that are ignored by LMHS on an ongoing basis. The issues for which you have asked me to address in this letter are as follows:

1. The forgiveness of debt given to the insurance companies, for which no Form 1099-C, Cancellation of Debt, is not being issued and no taxes are being paid.

2. The barter income given to the insurance companies, for which LMHS obtains valuable referrals of medical patients, is a write off of the patients' debt or the amount legally owed for medical goods/services provided to such patients.

3. The payment of illegal kickbacks, for which the taxable income of LMHS is not reduced for such kickbacks.

The primary source of revenue for LMHS is remuneration for providing medical goods and services to patients, on an individual contractual basis. The facts are such that providers of medical services such as LMHS typically issue a single bill for the services given to the patient and any responsible third-party payer and then issue a new bill for the co-payments and deductibles owed to the insurance companies. Third-party payers include entities such as private insurance companies and government payers such as Medicare and Medicaid. Medical bills which generate "receivables" for accrual basis taxpayers are issued as soon after the patient is discharged as all services and costs can be captured.

Providers have a standard charge for each specific good sold or service rendered. The standard charge amount, reflected on all bills issued, is the amount initially recorded as Gross Income and as an account receivable on the patient's account receivable and on the financial books of the LMHS when providing the services rendered or the good(s) sold.

Many medical service providers, such as LMHS has contractual agreements with a number of third-party payers regarding the amount that the third party 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 plans offered by the same payer. Thus, a provider typically receives different amounts from different payers and will consider such

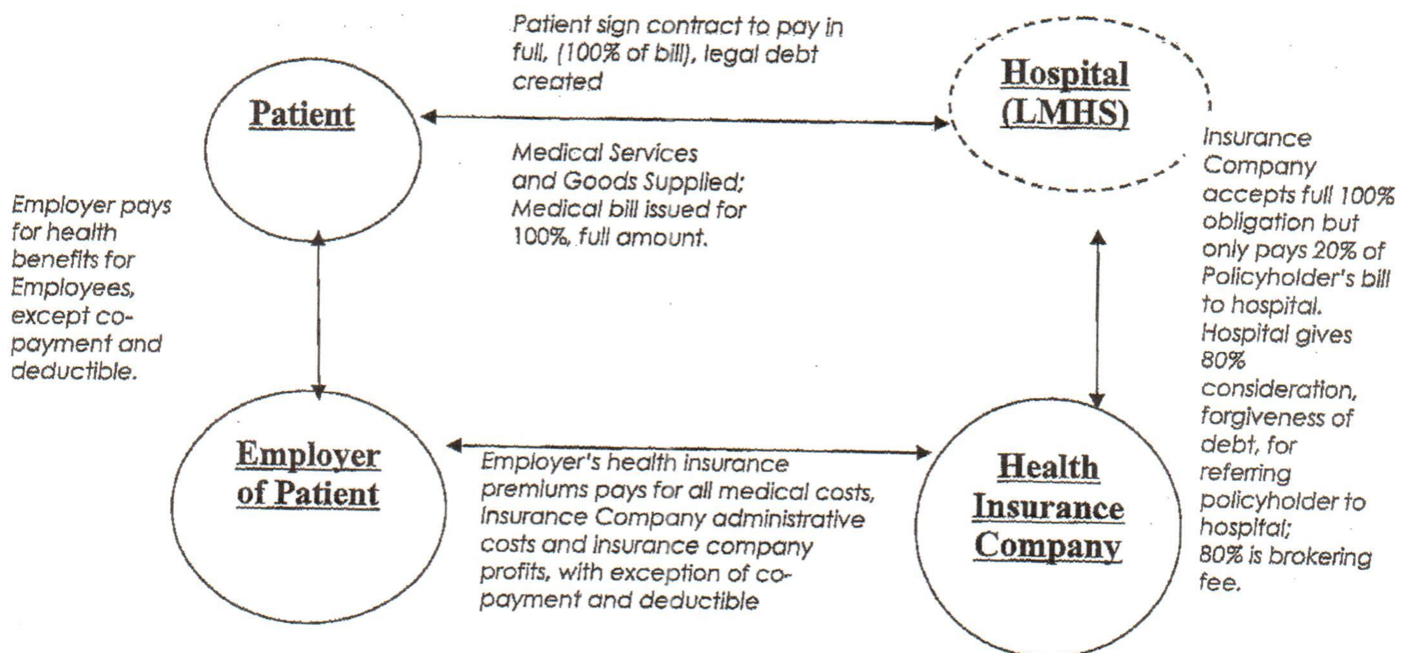
payments as full satisfaction of claims for the same goods or services provided. While ultimate payment of the actual amount due comes from one or all of the sources to whom bills are issued, payment from all sources is dictated by the terms of the contractual agreements in force between the medical service provider (LMHS) and the third party, rather than the Patient, (i.e. the consumer of the medical service/goods that is initially and ultimately liable for the full charges) and the medical service provider.

In reality, the contractual agreement with a third-party payer will ultimately govern the amount of payment that is ultimately paid, despite the fact that the patient is liable for the entire amount billed. An unrelated contract between the medical provider and a third party does not directly trump what the patient is ultimately liable for to the medical provider. At best, such a contract with a third party would indirectly trump what the patient is ultimately liable. Contract law states that the patients' contracts are the determining factor of what is owed or the legal debt and the actual amount of the recognized revenue.

Contractual allowances, given to the third party payer does not constitute bad debt or a reduction of gross income to the medical service provider, unless it is with a government program like Medicare or Medicaid. A provider's book contractual allowance represents the difference between the amount recorded on its books as a receivable at the time of the initial billing and the estimated net realizable value (NRV) of gross receipts reported for book purposes under GAAP for financial reporting. NRV is not an acceptable method of determining income for tax purposes.

In this situation, LMHS should not be allowed to do indirectly (write off amounts deemed uncollectible and avoid all tax consequences) for which they cannot do directly. Substance over form should govern.

In order to identify the relationship of the related parties and the underlying issues, the following diagram is being provided:



As shown above, and which is typical, LMHS and other medical service providers, all private pay non-Medicare patients, which includes both insured and un-insured patients, go the hospital for medical services. These non-Medicare patients sign the same contract with the medical provider (i.e. LMHS) obligating them to pay the full charges (100%) for the medical services that are received. Again, the non-Medicare patients and all patients are charged the same price for services. The charges for these medical services are simply referred to "**usual and customary charges**" and the same amount should be collected.

However, despite the contractual relationship with the patient to pay the usual and customary charges, the medical provider (i.e. LMHS) will collect vastly different amounts from primarily two different groups. In the example above, the hospital collects 100% of the full charges (i.e. usual and customary charges) from the un-insured (non-Medicare patients), while only collecting 20% from the insured patients.

The Insurance Companies, HMO plans, are required by both federal law and contractual law to accept the full legal obligation, the legal debt listed on the patient/policyholder's bill (again, usual and customary charges). Under this arrangement, there are:

1. No new bills are issued, for medical services;
2. there is not a re-pricing of the services; **nor**
3. are any discounts given.

The contract between the Hospital and the Insurance Company stands alone and has no bearing on the contract between the Patient and the Hospital. The contract between the Hospital and the Insurance Company is a means of establishing an on-network referral system for the hospital. As to the insurance company the contract typically limits the number of health care providers in the hospitals geographic area, for which the hospital pays a "consideration" to the insurance company (i.e. **barter income**).

The barter income, i.e. the consideration given to insurance company is the "forgiveness of debt" in exchange for the patient referrals. This forgiveness of debt is arguable a fee splitting arrangement between the parties. Although initially perhaps a difficult concept to grasp, the forgiveness of debt is simply a "kickback" from the hospital to the insurance company for gathering and referring a group of individuals (i.e. illegally brokering the policyholders/patients) for medical services. The contract between the Hospital and the Insurance Company requires that hospital reflect the usual and customary charges on the patient's bill, even though neither the patient nor the insurance company will ultimately be required to pay these charges. Bartering income such as discussed in this paragraph is considered income for tax purposes pursuant to Internal Revenue Code § 61. Therefore, despite that this so called forgiveness of debt from the kickbacks appears to be invisible and not hit the books and records for tax purposes, it must be recognized by the parties and properly reported on the tax returns of the parties.

The medical industry invokes this "shell game" on a nationwide basis. However, as discussed below, this shell game has tax consequences. These higher charges are utilized in establishing the Hospital's future "usual and customary charges" (i.e. adjusted for inflation). In addition, these "usual and customary charges" are posted in the hospital's charge master and are substantially higher than the negotiated fees that are to be placed on all patients' bills, especially the un-insured patients' bills and the Medicare/Medicaid beneficiaries' bills.

The Insurance Company will also utilize the "**usual and customary charges**" in determining the health insurance premiums to charge the Employers. Over all, the Insurance Company will create a state of fear and tension of patients with respect to the high "usual and customary charges" in order to force/encourage employees to put pressure on the employers to pay for their health care benefits. The Insurance companies also utilize the high usual and customary charges to justify their premium rates and the annual increases of the rates.

The insured policyholder is issued two bills.

1. The first is for medical goods and a service provided by the hospital which is covered by the insurance company.

2. The second is bill is for the co-payment and the medical deductible amount issued by the insurance company.

The final bill sent to the policyholder by the hospital combines both billing transactions into one bill.

Although perhaps simplified above, the relationship between the parties can become more complicated. For instance, there is often two different co-payment amounts billed by the insurance company,

1. The first is the amount negotiated with the employer and the insurance company which is based on the negotiated fees.

2. The second is an additional co-payment, negotiated by the on-network hospitals and the insurance company.

The second co-payment is only charged when a policyholder does not utilize an on-network health care provider. This second co-payment is usually an additional 20% to 25% or the full amount of the billed amount of the off-network health care provider, which the policyholder has to pay out of their pocket. This is used as duress, to force the policyholder to boycott any health care providers not on the insurance company's network.

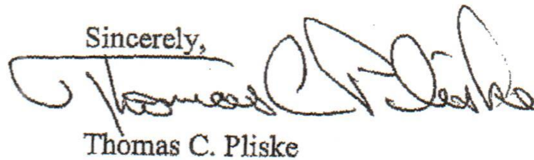
In summary the secret arrangements (i.e. contracts) between the Medical Service Providers (i.e. LMHS) and Insurance Companies can restrain trade by the use of boycotts and duress, fix the "usual and customary charges" charged to the un-insured patients and Medicare/Medicaid beneficiaries, and overcharge the Employers.

> The patient is not legally/contractually entitled to discounts for medical services for which the patient is liable for 100% of such fees, less any fees that may ultimately be paid by the insurance company.

In these 3rd party contractual situations, LMHS ultimately does not receive the actual amount billed for which the patient is liable, but it receives non-monetary benefits that have value. Although LMHS ultimately writes off what is not collected, it does so in violation of the Internal Revenue Code as it is receiving a valuable benefit (i.e. valuable patient referrals) in return and kickbacks cannot be written off. That benefit has value and must be included in income as barter income.

In conclusion, the kickbacks should have been reported to the government on the hospital's income tax return, and an information income tax return 1099-C, Cancellation of Debt, listing the amount and and the insurance company who received the kickback; and the insurance companies' income tax returns. At present, Lee Memorial Health System which consists of five hospitals is given kickbacks in excess of Four Hundred Million Dollars a year, without it being taxed.

Sincerely,



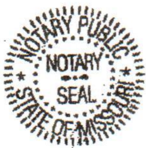
Thomas C. Pliske

State of Missouri)
)
County of St. Charles)

On this 8th day of February, 2010 before me, personally appeared Thomas C. Pliske who is known to me to be such individual or who proved to me on the basis of satisfactory evidence to be the person whose name is subscribed to the within instrument and acknowledged to me that he executed the same.

I certify under PENALTY OF PERJURY under the laws of the State of Missouri that the foregoing paragraph is true and correct.

WITNESS my hand and official seal.



SHINE LIN
My Commission Expires
November 22, 2013
St. Charles County
Commission #09899658

Signature **(Seal)**