UNITED STATES DISTRICT COURT
MIDDLE DISTRICT OF FLORIDA
FORT MYERS DIVISION

UNITED STATES OF AMERICA	)	
Ex rel. Roy Meidinger,	)	
18090 North Olga Drive	)	
Alva, Florida 33920	)	
	)	
Plaintiffs,	)	**CIVIL ACTION 99-101-**
	)	**CIV-FTM-20D**
vs.	)	
	)	
St. Joseph's Hospital, Inc.	)	
A Corporation: And all members of the	)	
Class of Defendants hereto and	)	
incorporated herein by reference	)	
	)	
Defendants	)	

FILED
99 AUG 24 PM 2:07

Affidavit of Affidavit Fax to Relator: Affidavit of Barry Steeley

Roy J. Meidinger states as Follows:

1. That I am the Relator in this case and over the age of 18.

2. That the attached work product: Affidavit of Barry Steeley, was sent to me via fax. Barry Steeley in my opinion is an expert because of his unit background. I have agreed to pay him a commercial fee for his services. He contacted because of notification in the news of my case. I firmly believe what he is stating in his affidavit is the truth.

FURTHER AFFIANT SAYETH NOT

Respectfully submitted,
Roy J. Meidinger, pro se

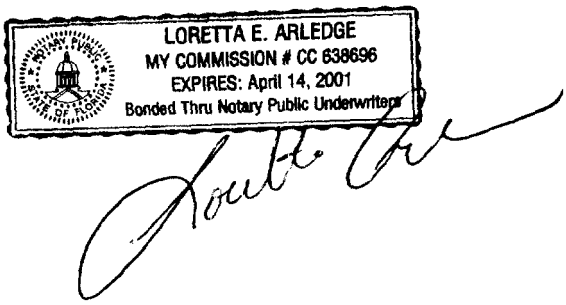
LORETTA D. ARLEDGE
MY COMM. [illegible] 38696
EXP. [illegible] 001
Bonded Thru Notary Public Underwriters

By Roy J. Meidinger
Roy J. Meidinger, pro se
18090 North Olga Drive

32

Alva, Florida 33920
941-694-5597

Before me personally appeared Roy J. Meidinger to me known and known to me to be the individual who executed this affidavit on this 22nd day of August, 1999.



CERTIFICATE OF SERVICE

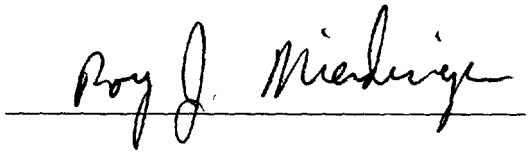
I HEREBY CERTIFY that a true and correct copy of the foregoing has been furnished to: Ms Jackie Hubbard Robinson, Assistant United States Attorney, 2100 First Street, Suite 3-137, Fort Myers Florida 33901.

Ms. Jamie Ann Yavelberg, Attorney Civil Division, U.S. Department of Justice, Post office Box 261, Ben Franklin Station, Washington, D.C. 20044

Mr. Steven Nisbet, Assistant United Stated Attorney, 400 North Tampa Street, Tampa, Florida 33602

Mr. Rodney W. Morgan, Esquire, Shear, Newman, Hahn, & Rosenkranz, First American Plaza. 201 East Kennedy Boulevard, 10th Floor, Tampa, Florida 33602

Respectfully submitted,
Roy J. Meidinger, pro se



AFFIDAVIT OF BARRY L. STEELEY

August 24, 1999

Background

I am the President of Health Audit Services, Incorporated. Health Audit Services is a consulting firm that provides services relating to Medicare and Medicaid policies and procedures. The Medicare and Medicaid programs are health insurance programs, funded in whole or part by the U.S. Government that provide coverage for the health expenses of the aged, disabled or indigent.

The advice and opinions that I provide relating to Medicare and Medicaid policies and procedures are based on my direct experience. The Health Care Financing Administration and the Office of Inspector General are parts of the Department of Health and Human Services. These agencies are responsible for developing policies, procedures and audit requirements relating to the Medicare and Medicaid programs. From the time that the Health Care Financing Administration was formed in March 1977 thought April of 1991, I held several key positions in the Health Care Financing Administration and the Office of Inspector General. From March 1977 through April 1986, I served as a Senior Policy Analyst first with the Health Care Financing Administration and then with the Office of Inspector General. During this time I was responsible for developing Medicare rules, regulations and policy instructions relating to Medicare services. I was also responsible for developing the policies and procedures used by Medicare contractors in performing their health care audits.

For the period April 1986 through April 1991, I was Chief of the Health Care Branch of the Office of Inspector General. In this capacity, I had responsibility for health care audits and investigations performed nationwide by the Office of Inspector General.

My opinions relating to whether certain services are properly reflected in Medicare cost reports and whether audit procedures were followed properly are based upon all relevant Medicare rules, regulations, the United States Code and my 14 years of experience in the development of policies and procedures relating to these rules and my subsequent work for the past seven years as a national expert on these matters.

Medicare Patient Liabilities

Health care services that are covered by Medicare are generally subject to certain deductibles and copayments amounts that are the financial responsibility of the Medicare beneficiary. Under Part A of Medicare, which covers inpatient hospital services, the deductible amount is a fixed amount for each inpatient stay. The amount of the Part A deductible is determined by the Health Care Financing Administration (HCFA) annually. The Medicare beneficiary's deductible and copayment amounts for Part B services, which includes all physician, clinic and hospital outpatient services is based on 20% of the Part B allowable charges. There is also a Medicare Part B annual deductible amount which is determined by HCFA.

In practice determining the Part B copayment works efficiently for most Part B services. For all Part B services other than services provided by a hospital, the beneficiary's liability is based on 20% of the Medicare approved amount. Consequently, the Medicare program pays 80% of the approved amount and the Medicare beneficiary is responsible for the remaining 20% of the approved amount. Generally, physicians and other provider of services are prohibited from collecting from the beneficiary more than this 20% (plus any deductible owed by the beneficiary).

For hospital outpatient services the copayment amount is based on 20% of the hospital charges for the services. However, Medicare's payment for most hospital out-patient services is based on the **hospital's costs** for performing the services not the **hospital's charges.** The practice of determining this beneficiary liability on a basis which is different from the basis for Medicare's payment determination can lead to substantial inequities both for Medicare beneficiaries and the Medicare program. During the past 15 years numerous Medicare reimbursement changes have placed limitations on the amount Medicare pays for hospital out-patient services.

First, it must be recognized the hospitals alone determine their charges for services. Therefore, if a hospital raises charges at a time when its costs remain the same this practice will increase the amount it can collect from the Medicare beneficiary even though the Medicare payment amount remains the same. During the time I conducted and directed audit work for the Office of Inspector General (1983-1991), our work documented that hospital charges for services increased at a rate that was substantially in excess of the increase in Medicare payments for these services. This resulted in a substantial increase in the amount owed by Medicare beneficiaries' for out-patient hospital services.

This increase in hospital charges was evident even in national data. In 1983, national hospital costs averaged 72% of the hospital charge amounts. By 1990, national hospital costs were only 50% of the hospital charge amounts. The difference in the Medicare patient's liability can be seen in the following hypothetical example. Assume that in 1983 there was an out-patient bill with hospital charges of $2,000, that the hospital is being paid by Medicare based on its costs and finally assume that the national averages shown in the above changes apply to this bill. In 1983, Medicare payment on the bill would have been $1,440 (the costs at 72% of $2,000) and the Medicare beneficiary would have been responsible for $400 (20% of the $2,000 charges) for a total paid to the hospital of $1,840.

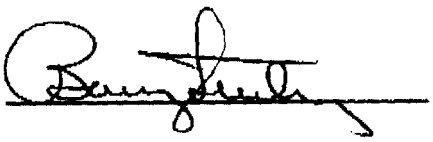
In 1990, a hospital out-patient bill representing $1,440 in costs (the same as in our 1983 example) would have represented $2,880 in hospital outpatient charges ($1,440 times 2 to account for the 50% cost to charge ratio). Under this example, the Medicare beneficiary's liability would have risen to $576 (20% of the hospital charges of $2,880) for a total of $1,976 total paid to the hospital. Consequently, even though the Medicare payments in our examples were constant at $1,440, the Medicare patient's lability increased from $400 to $576 an increase of 44%. (It should be pointed out that this example deals only with the amount of Medicare payment on the bills and does not take into account some hospital specific adjustments that could be made during the cost report settlement process. However, these adjustments are hospital specific and the effect of these adjustments can not be predicted in any national example).

The practice of increasing charges may also increase Medicare payments. This is true because Medicare includes as reimbursable Medicare costs, Medicare related bad debts. One inclusion in these costs is the amount of Medicare patient's liabilities that are uncollected by the hospital. If the uncollected amounts owed by Medicare patients increase then the hospital's allowable costs for Medicare bad debts increase. This would increase the amount of Medicare allowable costs for the hospital thereby increasing Medicare's cost reimbursements to the hospital. While it is likely that an increase in total amounts owed by Medicare beneficiaries as a result of increases in hospital charges for services would increase the total amount of Medicare costs, I do not have any data to confirm this.

CONCLUSION

Based on my experience as a Senior Policy Analyst and Official of the Office of Inspector General during the period 1983-1991, I conclude that hospitals substantially increased charges during this period thereby increasing the amount owed by Medicare beneficiaries for hospital out-patient services. I also believe that this increase in hospital charges could have had the effect of increasing Medicare costs for services during this period.

DATED: 08/24/99

SIGNED: 

252	RADIATION THERAPY AND HYPERTHERMIA	3.2	613	$2,191	$1,594
358	SIMPLE HEMATOLOGY TESTS	3.2	49,989	$27	$30
253	VASC RADIOLOGY X VENOGRAPHY OF EXTREMITY	3.2	477	$2,749	$1,204
080	MINOR VASCULAR REPAIR/FISTULA CONSTRUCT	2.8	162	$7,092	$3,491
010	SIMPLE SKIN REPAIR	2.7	182	$6,267	$513
123	COMPLEX LAPAROSCOPIC PROCEDURES	2.5	128	$8,133	$5,068
354	THERAPEUTIC DRUG MONITORING	2.5	14,934	$68	$64

Note 1 - APG classifications are based on the HCFA grouper, version 2.

More detailed information is available to subscribers

Subscription Information | Sample Report | Frequently Asked Questions

Visit the hospital's web site at: ***Address Not Available***

Click here for subscription information

The American Hospital Directory
is a service of QuadraMed Corporation.

American Hospital Directory
QuadraMed
1345 Campus Parkway
Neptune, NJ 07753
(800) 437-7220

Copyright © 1997-1999 QuadraMed, Inc. All Rights Reserved

The American Hospital Directory™

AHD Guest Services Report - Hospital Report

Saint Joseph's Hospital
PO Box 4227
3001 W Martin Luther King Blvd
Tampa , FL 33677-4227
(813)-870-4000

Hospital Characteristics

Hospital address, telephone, and ownership provided through SK&A Information Resources.
Other information is taken from the Provider of Services file for the period ending 12/31/97 and from the hospital's most recent cost report ending 6/30/97.
(See other hospital information available in our sample subscription report.)

Medicare Provider Number	100075
Type of Control	Voluntary Nonprofit, Church

	Available Beds	Inpatient Days
HOSPITAL (including swing beds)		
Routine Services	770	149,899
Special Care	79	22,553
Nursery	84	10,138
TOTAL Hospital	933	182,590
SUBPROVIDERS & DISTINCT UNITS		
Skilled Nursing Facility	19	6,454
Nursing Facility	0	0
Other	0	0
TOTAL COMPLEX:	952	189,044

Barry Steeley
Health Audit Services
Suite 224
8480-M Baltimore National Pike
Ellicott City, Maryland 21043
Telephone: (410) 461-4594

FAX COVER SHEET

FAX TRANSMISSION Fax Number: (410) 461-8560

DATE: 8/24/99

TO: ROY MEIDINGER

FAX NUMBER: 941-694-7813

PAGES: 9

For your review. Call with comments. Have you seen the attched data on Saint Joseph's? Their charges are quite a bit higher than norm.

Barry