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UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF OHIO
WESTERN DIVISION

In re CHEMED CORP. SECURITIES LITIGATION	No. 1:12-cv-00028-MRB

STIPULATION AND AGREEMENT OF SETTLEMENT

This Stipulation and Agreement of Settlement (the "Stipulation") is submitted pursuant to Rule 23 of the Federal Rules of Civil Procedure. Subject to the approval of the Court, this Stipulation is entered into among (i) Lead Plaintiffs Electrical Workers Pension Fund, Local 103, I.B.E.W., and Greater Pennsylvania Carpenters Pension Fund ("Lead Plaintiffs") on behalf of themselves and the proposed Settlement Class defined herein (together, "Plaintiffs") and (ii) defendants Chemed Corporation ("Chemed"), Kevin McNamara, David Williams, and Timothy O'Toole (collectively, "Defendants"), by and through their respective counsel. Plaintiffs and Defendants are referred to herein as the "Settling Parties."

WHEREAS,

A. All words or terms used herein that are capitalized shall have the meaning ascribed to those words or terms as set forth herein and in Paragraph 1 hereof entitled "Definitions;"

B. This action was commenced on January 12, 2012, by plaintiff Greater Pennsylvania Carpenters Pension Fund through the filing of a putative class action Complaint ("Complaint") alleging violations by Defendants of Sections 10(b) and 20(a) of the Securities Exchange Act of 1934 ("Exchange Act") and Rule 10b-5 promulgated thereunder;

C. By Order dated April 9, 2012, the Court issued an order (i) establishing a master file under the caption In re Chemed Corp. Securities Litigation, Case No. 1:12-cv-28 (S.D. Ohio) (the "Action"); and (ii) appointing the Electrical Workers Pension Fund, Local 103, I.B.E.W. and the Greater Pennsylvania Carpenters Pension Fund as Lead Plaintiffs in this Action and Labaton Sucharow LLP and Robbins Geller Rudman & Dowd LLP as Co-Lead Counsel for the proposed class ("Co-Lead Counsel");

D. On June 18, 2012, Lead Plaintiffs filed an Amended Complaint ("Amended Complaint") alleging, on behalf of a putative class of purchasers of Chemed capital stock, violations by Defendants of Sections 10(b) and 20(a) of the Exchange Act and Rule 10b-5 promulgated thereunder;

E. On August, 17, 2012, Defendants filed motions to dismiss the Amended Complaint. Lead Plaintiffs opposed those motions, which were fully briefed as of November 26, 2012. The Court has not yet ruled on Defendants' motions to dismiss;

F. Defendants have denied and continue to deny each and every allegation of wrongdoing that has or could have been asserted by or on behalf of Lead Plaintiffs and/or members of the putative class, including, but not limited to, all contentions concerning Defendants' business, conduct and public statements, as well as contentions that any such conduct or events constitute wrongdoing or give rise to legal liability or has caused damage to Lead Plaintiffs or putative class members. Defendants have not conceded or admitted any liability and disclaim any and all wrongdoing and liability whatsoever. Further, this Stipulation, whether or not consummated, together with any proceedings related to any settlement, or any terms of any settlement, whether or not consummated, shall in no event be construed as or deemed to be evidence supporting, or an admission or concession on the part of any Defendant

with respect to, any claim or of any fault or liability or wrongdoing or damage whatsoever, or any infirmity in any of the defenses that any of the Defendants have or could have asserted. Defendants state that they are entering into this Settlement (as defined below) solely in order to eliminate the burden, expense, uncertainty and risk of further litigation, and to avoid the business disruptions associated therewith;

G. This Stipulation shall not be construed or deemed to be a concession by any Lead Plaintiff or putative class member of any infirmity in any of the claims asserted in the Action. The Settling Parties recognize that this Action was filed by Lead Plaintiffs and defended by Defendants in good faith, and neither Lead Plaintiffs, Defendants nor their respective counsel shall make any applications for sanctions pursuant to Rule 11 of the Federal Rules of Civil Procedure or other court rule or statute with respect to any claims or defenses asserted in this Action;

H. The parties to this Stipulation acknowledge and agree that this Action is being voluntarily settled after advice of counsel. With the assistance of former Vice Chancellor of Delaware Court of Chancery Stephen Lamb acting as a mediator, Co-Lead Counsel conducted lengthy discussions and arm's-length negotiations with counsel for Defendants on September 16, 2013, with a view to achieving a compromise and settlement of this Action and all issues in dispute therein, and achieving the best relief possible consistent with the best interests of the proposed Settlement Class. As a result of those discussions, the Settling Parties have agreed to settle this Action and all issues in dispute therein on the terms set forth in this Stipulation;

I. Based upon their investigation, consultation with experts, and the assistance of the mediator as set forth above, Lead Plaintiffs and Co-Lead Counsel believe that the terms and conditions of this Stipulation are fair, reasonable and adequate to Lead Plaintiffs and the

proposed Settlement Class, and in their best interests, and have agreed to settle the claims raised in the Action pursuant to the terms and provisions of this Stipulation, after considering (i) the substantial benefits that Lead Plaintiffs and the members of the proposed Settlement Class will receive from settlement of the Action as against Defendants, (ii) the attendant risks of litigation, and (iii) the desirability of permitting the Settlement to be consummated as provided by the terms of this Stipulation; and

J. Defendants believe that further conduct of this Action would be protracted and expensive, and that it is desirable that this Action be fully and finally settled with the proposed Settlement Class as defined herein in the manner and upon the terms and conditions set forth in this Stipulation to limit further expense, inconvenience and distraction, to dispose of the burden of protracted litigation, and to permit the operation of Chemed's business without further distraction and diversion of Chemed's executives and other personnel with respect to the matters at issue in this Action. Defendants have also taken into account the uncertainty and risks inherent in any litigation;

NOW, THEREFORE, without any admission or concession on the part of Lead Plaintiffs of any lack of merit of the Action whatsoever, and without any admission or concession of any liability or wrongdoing or lack of merit of any defenses thereto whatsoever by Defendants, it is hereby **STIPULATED AND AGREED**, by and among the parties to this Stipulation, through their respective attorneys, subject to approval of the Court pursuant to Rule 23(e) of the Federal Rules of Civil Procedure, in consideration of the benefits flowing to the Settling Parties hereto from the Settlement, that all Settled Claims (as defined below) as against the Releasees (as defined below) and all Settled Defendants' Claims (as defined below) as

against the Releasors (as defined below) shall be compromised, settled, released and dismissed fully, finally and with prejudice, upon and subject to the following terms and conditions:

I. DEFINITIONS

1. As used in this Stipulation, the following terms shall have the following meanings:

(a) "Authorized Claimant" means a Settlement Class Member who timely submits a valid Proof of Claim form to the Claims Administrator that is accepted for payment.

(b) "Alternative Judgment" means a form of final judgment that may be entered by the Court herein but in a form other than the form of Judgment provided in Exhibit B hereto where none of the Settling Parties elects to terminate this Settlement by reason of such variance.

(c) "Claimant" means a person or entity that submits a Proof of Claim form to the Claims Administrator seeking to share in the proceeds of the Settlement of this Action.

(d) "Claims Administrator" means the firm to be retained by Co-Lead Counsel, subject to Court approval, to provide all notices approved by the Court to Settlement Class Members, to process proofs of claim, and to administer the Settlement.

(e) "Class Period" means, for the purposes of this Settlement only, the period from February 15, 2010, through May 2, 2013, inclusive.

(f) "Co-Lead Counsel" means Labaton Sucharow LLP and Robbins Geller Rudman & Dowd LLP.

(g) "Court" means the United States District Court for the Southern District of Ohio, The Honorable Michael R. Barrett presiding.

(h) "Defendants" means Chemed Corporation, Kevin McNamara, David Williams, and Timothy O'Toole.

(i) "Defendants' Counsel" means the law firms of Cravath, Swaine & Moore LLP and Dinsmore & Shohl LLP.

(j) "Effective Date" means the first date by which all the events and conditions specified in Paragraph 29 of this Stipulation have occurred and been met.

(k) "Entity" means any non-natural person.

(l) "Execution Date" means the date of execution of this Stipulation and shall be the date that the Stipulation is fully executed by the parties.

(m) "Escrow Account" means the interest-bearing escrow account to be established by the Escrow Agent at a federally-insured banking institution into which the Settlement Amount shall be deposited.

(n) "Escrow Agent" means Robbins Geller Rudman & Dowd LLP.

(o) "Final," with respect to a court order, means the later of: (i) if there is an appeal from a court order, the date of final affirmance on appeal and the expiration of the time for any further judicial review whether by appeal, reconsideration or a petition for a *writ of certiorari* and, if *certiorari* is granted, the date of final affirmance of the order following review pursuant to the grant; or (ii) the date of final dismissal of any appeal from the order or the final dismissal of any proceeding on *certiorari* to review the order; or (iii) the expiration of the time for the filing or noticing of any appeal or petition for *certiorari* from the order (or, if the date for taking an appeal or seeking review of the order shall be extended beyond this time by order of the issuing court, by operation of law or otherwise, or if such extension is requested, the date of expiration of any extension if any appeal or review is not sought). However, any appeal or proceeding seeking subsequent judicial review pertaining solely to the Plan of Allocation of the Net Settlement Fund, or to the Court's award of attorneys' fees or expenses, shall not in any way

delay or affect the time set forth above for the Judgment or Alternative Judgment to become Final, or otherwise preclude the Judgment or Alternative Judgment from becoming Final.

(p) "Individual Defendants" means Kevin McNamara, David Williams and Timothy O'Toole.

(q) "Judgment" means the proposed judgment to be entered approving the Settlement substantially in the form attached hereto as Exhibit B, terminating, pursuant to Federal Rule of Civil Procedure 54(b), all proceedings of any kind in this Action as between Plaintiffs (including the Settlement Class) and Defendants and dismissing the Action and all claims therein against Defendants with prejudice as to all Releasors.

(r) "Lead Plaintiffs" means Electrical Workers Pension Fund, Local 103, I.B.E.W., and Greater Pennsylvania Carpenters Pension Fund.

(s) "Net Settlement Fund" means the Settlement Fund less (i) Court-awarded attorneys' fees and expenses; (ii) Notice and Administration Expenses; (iii) Taxes or Tax Expenses; and (iv) any other fees or expenses approved by the Court.

(t) "Notice" means the Notice of Pendency of Class Action and Proposed Settlement, Motion for Attorneys' Fees and Settlement Hearing, which is to be sent to Members of the Settlement Class in, or substantially in, the form attached hereto as Exhibit 1 to Exhibit A hereto.

(u) "Notice and Administration Expenses" means all costs, fees, and expenses incurred in connection with providing notice to the Settlement Class and the administration of the Settlement, including but not limited to: (i) providing notice of the proposed Settlement by mail, publication, and other means to Settlement Class Members; (ii) receiving and reviewing claims; (iii) applying the Plan of Allocation; (iv) communicating with persons and Entities

regarding the proposed Settlement and claims administration process; (v) distributing the proceeds of the Settlement; and (vi) fees related to the Escrow Account and investment of the Settlement Fund.

(v) "Plaintiffs" means Lead Plaintiffs and the Settlement Class defined herein.

(w) "Plaintiffs' Counsel" means Co-Lead Counsel and all other counsel representing Settlement Class Members in the Action.

(x) "Plan of Allocation" means the plan and procedures for allocating the Net Settlement Fund among Authorized Claimants.

(y) "Preliminary Approval Order" means the proposed order substantially in the form attached hereto as Exhibit A confirming that Lead Plaintiffs may file the proposed Second Amended Complaint annexed as Exhibit 4 to Exhibit A hereto, preliminarily approving the Settlement upon the terms set forth in this Stipulation, authorizing dissemination of notice to the Settlement Class, and scheduling a Settlement Hearing.

(z) "Proof of Claim" or "Proof of Claim Form" means the proof of claim and release form substantially in the form attached as Exhibit 2 to Exhibit A hereto.

(aa) "Publication Notice" means the summary notice of proposed Settlement and hearing for publication substantially in the form attached as Exhibit 3 to Exhibit A hereto.

(bb) "Releasees" refers jointly and severally, individually and collectively to Individual Defendants, Chemed, and its past, present, and future direct and indirect parents, subsidiaries, divisions and affiliates, and their respective present and former officers, directors, employees, managers, agents, insurers, attorneys and legal representatives, and the predecessors, successors, heirs, executors, trustees, administrators and assigns of each of the foregoing. As used in this Paragraph, "affiliates" means entities controlling, controlled by or under common

control with Chemed. The Releasees are express third-party beneficiaries of this Stipulation and Agreement of Settlement.

(cc) "Releasors" refers jointly and severally, individually and collectively, to Lead Plaintiffs and all Settlement Class Members, and their past, present and future direct and indirect parents, subsidiaries, divisions and affiliates, and their respective present and former officers, directors, employees, managers, agents, attorneys and legal representatives, and the predecessors, successors, heirs, executors, trustees, administrators and assigns of each of the foregoing. As used in this Paragraph, "affiliates" means entities controlling, controlled by or under common control with Releasors.

(dd) "Second Amended Complaint" means the complaint, attached as Exhibit 4 to Exhibit A hereto, asserting substantially the same claims and seeking substantially the same relief as the Amended Complaint, on behalf of a putative class of purchasers of Chemed capital stock for an expanded class period of between February 15, 2010, and May 2, 2013, inclusive.

(ee) "Settled Claims" means any and all claims (including any claim that this Stipulation was fraudulently induced), debts, demands, rights, actions, suits, causes of action or liabilities whatsoever (including, but not limited to, any and all claims for damages, interest, attorneys' fees, expert or consulting fees, and any other costs, expenses or liability whatsoever), whether based on federal, state, local, statutory, or common law, or any other law, rule or regulation (whether foreign or domestic), whether class or individual in nature, including both known claims and Unknown Claims, (i) that have been asserted in this Action by or on behalf of the Settlement Class Members or any of them against any of the Releasees (including without limitation all claims and allegations in the Complaint, the Amended Complaint and/or the Second Amended Complaint), or (ii) that could have been asserted in any forum by or on behalf

of the Releasors now or in the future, or any of them, against any of the Releasees or Defendants' Counsel that relate to, or that in any way arise out of, or are based upon, the allegations, transactions, facts, matters or occurrences, acts, disclosures, statements, representations, omissions, or failures to act involved, set forth, or referred to in any of the complaints or proposed complaints filed in this Action, including but not limited to the Complaint, the Amended Complaint and/or the Second Amended Complaint, and that relate to the purchase, acquisition, or sale of the capital stock of Chemed during the Class Period. For the avoidance of doubt, Settled Claims do not include: (i) claims to enforce the Settlement; (ii) *KBC Asset Management NV, et al. v. Kevin J. McNamara, et al.*, No. 13-cv-01854-UNA (D. Del.); (iii) *North, et al. v. Kevin J. McNamara, et al.*, No. 1:13-cv-00833-MRB (S.D. Ohio); and (iv) any governmental or regulatory agency's claims in, or any right to relief from, any criminal or civil action against any of the Releasees.

(ff) "Settled Defendants' Claims" means any and all claims (including any claim that this Stipulation was fraudulently induced), rights or causes of action or liabilities whatsoever, whether based on federal, state, local, statutory or common law or any other law, rule or regulation (whether foreign or domestic), including both known claims and Unknown Claims, that have been or could have been asserted in the Action or any forum by Releasees or their successors and assigns of any of them against any of the Lead Plaintiffs, Releasors or Plaintiffs' Counsel, which arise out of or relate in any way to the institution, prosecution, or settlement of the Action (except for claims to enforce the Settlement).

(gg) "Settlement" means the settlement contemplated by this Stipulation.

(hh) "Settlement Amount" means the sum of Six Million Dollars ($6,000,000.00), payable in United States currency.

(ii) "Settlement Class", "Settlement Class Member" and "Settlement Class Members" mean, for the purposes of this Settlement only, all persons or entities that purchased or otherwise acquired Chemed capital stock during the period from February 15, 2010, through May 2, 2013, inclusive, and who were damaged thereby. Excluded from the Settlement Class are: (i) the Defendants; (ii) the officers and directors of Chemed, at any point during the Class Period; (iii) members of the immediate family of each of the Individual Defendants and the officers and directors of Chemed, at any point during the Class Period; (iv) any entity in which Defendants have or had a controlling interest; and (v) the legal representatives, heirs, predecessors, successors or assigns of any such excluded party. Also excluded from the Settlement Class are any putative Settlement Class Members who validly exclude themselves from the Settlement Class by timely filing a request for exclusion in accordance with the requirements set forth in the Preliminary Approval Order and the Notice.

(jj) "Settlement Hearing" means the hearing to be held to determine whether the proposed Settlement embodied by the Stipulation is fair, reasonable and adequate to the Settlement Class, and whether the Court should enter the Judgment finally approving the Settlement.

(kk) "Settlement Fund" means the Settlement Amount and any interest earned thereon following the deposit of the Settlement Amount into the Escrow Account in accordance with Paragraph 4 herein.

(ll) "Settling Parties" means Plaintiffs and Defendants.

(mm) "Taxes" means any taxes (including any estimated taxes, interest or penalties) arising with respect to any income earned by the Settlement Fund, including any taxes or tax detriments to which Defendants are subject (as computed on a "first-dollar" basis) with

respect to (i) any income earned by the Settlement Fund for any period during which the Settlement Fund is not treated, or does not qualify, as a "qualified settlement fund" for federal or state income tax purposes; and (ii) the payment or reimbursement of the Settlement Fund of any taxes or tax detriments described in clause (i) of this Paragraph.

(nn) "Tax Expenses" means expenses and costs incurred in connection with the operation and implementation of Paragraph 9 herein (including expenses of tax attorneys and/or accountants and mailing and distribution costs and expenses relating to filing, or failing to file, the returns described in Paragraph 9).

(oo) "Unknown Claims" means any and all Settled Claims which any Lead Plaintiff or Releasor does not know or suspect to exist in his, her or its favor at the time the release of the Releasees, and any Settled Defendants' Claims which any Defendant or Releasee does not know or suspect to exist in his, her or its favor, which if known by him, her or it might have affected his, her or its decision(s) with respect to the Settlement. With respect to any and all Settled Claims and Settled Defendants' Claims, the Settling Parties stipulate and agree that upon the Effective Date, the Lead Plaintiffs and the Defendants shall expressly waive, and each Releasor and Releasee shall be deemed to have waived, and by operation of the Judgment or Alternative Judgment shall have expressly waived, any and all provisions, rights and benefits of conferred by any law of any state or territory of the United States, or principle of common law, which is similar comparable, or equivalent to Cal. Civ. Code § 1542, which provides:

> A GENERAL RELEASE DOES NOT EXTEND TO CLAIMS WHICH THE CREDITOR DOES NOT KNOW OR SUSPECT TO EXIST IN HIS OR HER FAVOR AT THE TIME OF EXECUTING THE RELEASE, WHICH IF KNOWN BY HIM OR HER MUST HAVE MATERIALLY AFFECTED HIS OR HER SETTLEMENT WITH THE DEBTOR.

Releasors may hereafter discover facts in addition to or different from those which he, she, or it now knows or believes to be true with respect to the subject matter of the Settled Claims, but each of them hereby stipulates and agrees that the Lead Plaintiffs, and each Releasor shall be deemed to settle and release, and upon the Effective Date and by operation of the Judgment or Alternative Judgment shall have settled and released, fully, finally, and forever, and all Settled Claims against Releasees, known or unknown, suspected or unsuspected, contingent or non-contingent, whether or not concealed or hidden, which now exist, or which heretofore existed upon any theory of law or equity now existing or coming into existence in the future, including, but not limited to, conduct that is negligent or intentional and with or without malice, or a breach of any duty, law, or rule, without regard to the subsequent discovery or existence of such different or additional facts. Similarly, Defendants may hereafter discover facts in addition to or different from those which he, she, or it now knows or believes to be true with respect to the subject matter of Settled Defendants' Claims, but each of them hereby stipulates and agrees that Defendants, and Releasees shall be deemed upon the Effective Date and by operation of the Judgment or Alternative Judgment, to have fully, finally, and forever settled and released any and all Settled Defendants' Claims against Releasors, known or unknown, suspected or unsuspected contingent or non-contingent, whether or not concealed or hidden, which now exist, or heretofore have existed upon any theory of law or equity now existing or coming into existence in the future, including, but not limited to, conduct which is negligent, intentional, with or without malice, or a breach of any duty, law, or rule, without regard to the subsequent discovery or existence of such different or additional facts. Lead Plaintiffs and Defendants acknowledge, and all other Releasors and Releasees by operation of law shall be deemed to have acknowledged, that the inclusion of "Unknown Claims" in the definition of Settled Claims and

Settled Defendants' Claims was separately bargained for and was a key element of the Settlement.

II. SCOPE AND EFFECT OF SETTLEMENT

2. The obligations incurred pursuant to this Stipulation shall be in full and final disposition of the Action and any and all Settled Claims.

3. (a) By operation of the Judgment or Alternative Judgment, upon the Effective Date of this Settlement, each and all of the Lead Plaintiffs and Releasors, on behalf of themselves and their respective heirs, executors, administrators, successors and assigns and all persons acting in concert with any such person shall, with respect to each and every Settled Claim, waive, release, forever discharge and dismiss, with prejudice, and agree not to institute, maintain or prosecute any or all Settled Claims against any or all of the Releasees, and shall be permanently and finally enjoined without the necessity of posting a bond from commencing or prosecuting any actions or other proceedings asserting any of the Settled Claims either directly, indirectly, or representatively against any of the Releasees or Defendants' Counsel herein. This injunction expressly extends to all claims covered by this Stipulation and all Releasors defined herein.

(b) By operation of the Judgment or Alternative Judgment, upon the Effective Date of this Settlement, each of the Defendants and Releasees, on behalf of themselves and their respective heirs, executors, administrators, successors and assigns and all persons acting in concert with any such person, shall, with respect to each and every Settled Defendants' Claims, waive, release, forever discharge and dismiss, with prejudice, and agree not to institute, maintain or prosecute any or all Settled Defendants' Claims against any or all of the Releasors or Plaintiffs' Counsel, and shall be permanently and finally enjoined without the necessity of posting a bond from commencing or prosecuting any actions or other proceedings asserting any

of the Settled Defendants' Claims either directly, indirectly, or representatively against any of the Releasors or Plaintiffs' Counsel herein. This injunction expressly extends to all claims covered by this Stipulation and all Releasees defined herein.

III. THE SETTLEMENT CONSIDERATION

4. Within ten (10) business days following entry on the Court's docket of the Preliminary Approval Order, either in or substantially in the form annexed hereto as Exhibit A, granting the Court's preliminary approval of this Settlement, Defendants shall cause the Settlement Amount to be deposited into the Escrow Account, in full and complete settlement of the Settled Claims of Lead Plaintiffs and all Releasors. Upon deposit of the Settlement Amount into the Escrow Account, the Settlement Amount and any income or interest earned thereon thereafter shall be the "Settlement Fund". In no event shall Defendants or their insurers be liable for or required to pay any amounts of any kind in addition to the Settlement Amount to Lead Plaintiffs, Settlement Class Members or Co-Lead Counsel or in addition to the obligations in Paragraph 7, including without limitation, interest on the Settlement Amount of any kind and relating to any time period (including prior to the payment of the Settlement Amount into the Escrow Account) and payment to Settlement Class Members of their attorneys' fees or reimbursement of any other fees or expenses.

5. In no event shall Defendants have any responsibility, financial obligation, or liability whatsoever with respect to the operation, management or disbursement of the Escrow Account once established or with respect to the investment, distribution, use, or administration of the Settlement Fund, including, but not limited to, the costs and expenses of such investment, distribution, or administration. Defendants shall likewise have no responsibility whatsoever for the allocation or distribution of the Settlement Fund and shall not be responsible or otherwise liable, including to or with Lead Plaintiffs, Co-Lead Counsel, any Settlement Class Member or

the Claims Administrator, for any disputes relating to the amount, allocation, or distribution of any fees, costs, or awards of any kind. After making payment of the Settlement Amount in accordance with Paragraph 4 herein or satisfying the obligations in Paragraph 7 herein, Defendants shall not be liable for any additional payments of any kind to Settlement Class Members, Co-Lead Counsel or to any other person or entity with respect to this Settlement or Stipulation.

IV. ATTORNEYS' FEES AND EXPENSES

6. Co-Lead Counsel will apply to the Court for a collective award of attorneys' fees from the Settlement Fund. Co-Lead Counsel will also apply to the Court for reimbursement of litigation expenses. Defendants take no position with respect to Co-Lead Counsel's request for an award of attorneys' fees and reimbursement of expenses. Such matters are not the subject of any agreement between the Settling Parties. Such attorneys' fees and expenses as are awarded by the Court shall be payable to Co-Lead Counsel from the Settlement Fund immediately upon award, notwithstanding the existence of any timely filed objections thereto, or potential for appeal therefrom, or collateral attack on the Settlement or any part thereof, subject to Co-Lead Counsel's joint and several obligation to make appropriate refunds or repayments to the Settlement Fund of the awarded attorneys' fees and litigation expenses, plus accrued interest at the same net rate as is earned by the Settlement Fund, if and when, as a result of any appeal and/or further proceedings on remand, or successful collateral attack, the fee or cost award is reduced or reversed by Final order or the Settlement is otherwise terminated. Co-Lead Counsel shall make the appropriate refund or repayment in full to the Settlement Fund within ten (10) business days following any such reduction of the fee or cost award, or termination of the Settlement. Co-Lead Counsel may make a supplemental application to the Court for an award of attorneys' fees and expenses with respect to post-settlement proceedings and administration. In

no event will any Defendant or Defendants' insurers be requested or required to pay, or be liable in any way for, any plaintiffs' attorneys' fees, expenses or costs of any kind.

V. ADMINISTRATION EXPENSES

7. Co-Lead Counsel shall be solely responsible for designating a Claims Administrator, subject to approval by the Court. The Claims Administrator shall administer the Settlement under Co-Lead Counsel's supervision and subject to the jurisdiction of the Court. Except as set forth in this Paragraph 7, Defendants will not have any responsibility for, involvement in, or liability for, and Defendants will not be requested or required to pay any costs, fees or expenses in connection with, providing notice to the Settlement Class, the administration of the Settlement, the allocation, disbursement and payment of the Settlement proceeds, or the reviewing, challenging or determination of claims of Settlement Class Members. Defendants shall cooperate in the administration of the Settlement to the extent reasonably necessary to effectuate its terms, including providing information in electronic searchable format from Chemed's transfer records concerning the identity of Settlement Class Members and their transactions in Chemed capital stock during the Class Period. Any charges, fees or expenses incurred by Chemed for providing this information, to the extent there are any, will be paid by Chemed.

8. All reasonable Notice and Administration Expenses shall be paid from the Settlement Fund when incurred, except that prior to the Effective Date, Co-Lead Counsel may only draw on the Settlement Fund in an amount not exceeding $200,000 to pay Notice and Administration Expenses incurred. Taxes, Tax Expenses and fees related to the Escrow Account and investment of the Settlement Fund may be paid from the Settlement Fund as incurred, without further approval of the Defendants, their insurers or further order of the Court. After the

Effective Date, without approval of the Defendants, their insurers or further order of the Court, Notice and Administration Expenses may be paid from the Settlement Fund as incurred.

VI. USE AND TAX TREATMENT OF SETTLEMENT FUND

9. (a) The Settling Parties agree that the Settlement Fund is intended to be, and shall be treated as being, a "qualified settlement fund" within the meaning of Treasury Regulation 1.468B-1. Co-Lead Counsel shall administer the Settlement Fund and shall be the "administrator" (within the meaning of Treasury Regulation 1.468B-2(k)(3)) (the "Administrator").

(b) The Administrator and, as required, the Settling Parties, shall timely make, or cause to be made, such elections as necessary or advisable to carry out the provisions of this Paragraph 9, including the "relation-back election" (as defined in Treasury Regulation 1.468B-1) back to the earliest permitted date. The Administrator shall timely and properly prepare and deliver, or cause to be prepared and delivered, the necessary documentation for signature by all necessary parties, and shall cause the appropriate filings to occur.

(c) The Administrator shall timely and properly file, or cause to be filed, all informational and other tax returns necessary or advisable with respect to the Settlement Fund (including the returns described in Treasury Regulation 1.468B-2(k) and (*l*) and the "§ 1.468B-3 Statement"). Such returns shall reflect that all Taxes shall be paid out of the Settlement Fund.

(d) Taxes and Tax Expenses shall be treated as, and considered to be, a cost of administration of the Settlement and shall be timely paid or reimbursed, or caused to be paid or reimbursed, by the Administrator from the Settlement Fund without prior order from the Court. The Administrator shall reimburse the Defendants out of the Settlement Fund for Taxes and Tax Expenses to which the Defendants are subject on any earnings on the funds on deposit in the Settlement Fund. The Administrator shall be obligated (notwithstanding anything herein to the

contrary) to withhold from distribution out of the Settlement Fund any funds necessary to pay or reimburse any Taxes or Tax Expenses, as well as any amounts that may be required to be withheld under Treasury Regulation 1.468B-2(*l*)(2).

(e) It is the sole responsibility of the Settlement Class Members to pay Taxes or any other taxes, plus any penalties and interest, on any amounts received pursuant to the Settlement that are construed to be income, and the Settlement Fund, Lead Plaintiffs, Co-Lead Counsel, Defendants, their insurers, and Defendants' Counsel shall have no liability for such taxes, penalties or interest.

10. This is not a claims-made settlement. As of the Effective Date, Defendants and/or such other persons or entities funding the Settlement on the Defendants' behalf, shall not have any right to the return of the Settlement Fund or any portion thereof for any reason.

VII. DISTRIBUTION TO AUTHORIZED CLAIMANTS

11. The Claims Administrator shall determine each Authorized Claimant's *pro rata* share of the Net Settlement Fund based upon a Plan of Allocation to be proposed by Co-Lead Counsel and approved by the Court. The Defendants will take no position with respect to such proposed Plan of Allocation.

12. The Plan of Allocation to be proposed by Co-Lead Counsel is not a necessary term of this Stipulation and it is not a condition of this Stipulation that any particular Plan of Allocation be approved. Any decision by the Court concerning the Plan of Allocation shall not affect the validity or finality of this Stipulation or Settlement.

13. The Net Settlement Fund shall be distributed to Authorized Claimants by the Claims Administrator only after the Effective Date and after: (i) all claims have been processed, and all Claimants whose claims have been rejected or disallowed, in whole or in part, have been notified and provided the opportunity to be heard concerning such rejection or disallowance;

(ii) all objections with respect to all rejected or disallowed claims have been resolved by the Court, and all appeals therefrom have been resolved or the time therefore has expired; (iii) all matters with respect to attorneys' fees, costs, and disbursements have been resolved by the Court, all appeals therefrom have been resolved or the time therefore has expired; and (iv) all Notice and Administration Expenses, Taxes and Tax Expenses have been paid. If the funds remaining in the Settlement Fund following *pro rata* distribution(s) to all Authorized Claimants are an amount that it is not cost effective or efficient to redistribute to Authorized Claimants, then such remaining funds, after payment of any further Notice and Administration Expenses, Taxes and Tax Expenses, shall be contributed to the Legal Aid Society of Greater Cincinnati, a non-sectarian, not-for-profit, 501(c)(3) organization.

14. The Defendants shall have no involvement in, and shall not be responsible or liable in any way for, reviewing or challenging submitted Proofs of Claim.

VIII. ADMINISTRATION OF THE SETTLEMENT

15. Any Member of the Settlement Class who does not timely submit a valid Proof of Claim will not be entitled to receive any proceeds from the Net Settlement Fund but will otherwise be bound by all of the terms of this Stipulation and the Settlement, including the terms of the Judgment or Alternative Judgment to be entered in the Action and the releases provided for herein, and will be barred and enjoined from bringing any action against the Releasees concerning the Settled Claims.

16. All Claimants shall, as part of the Proof of Claim, execute an individual release of the Releasees upon the same terms as set forth herein, as a condition precedent to receipt of any part of the Settlement Fund, but the failure of any Claimant to execute such a release shall not in any way affect the validity of the releases provided by Releasors in favor of Releasees herein, including pursuant to Paragraphs 1(ee) and (oo) and 3(a) hereof, and Releasors shall nonetheless

be bound by the terms of those releases. Further, the failure of any Releasor to make a claim on the Settlement Fund shall not affect the validity and effectiveness of the release provided herein in favor of Releasees, including pursuant to Paragraphs 1(ee) and (oo) and 3(a) hereof, as to that Releasor. Co-Lead Counsel and/or the Claims Administrator shall retain copies of the individual releases executed by Claimants referred to in this Paragraph for at least three (3) years after the disbursement of the Net Settlement Fund by the Claims Administrator and shall provide copies of individual releases to Defendants' Counsel at no expense on a case by case basis if requested to do so.

17. Co-Lead Counsel shall be solely responsible for supervising the administration of the Settlement and disbursement of the Net Settlement Fund by the Claims Administrator. Except for the obligation to pay the Settlement Amount and, as set forth in Paragraph 7 above, to provide reasonable cooperation with respect to the identification of Settlement Class Members from Chemed's shareholder transfer records, Defendants shall have no liability, obligation or responsibility for the administration of the Escrow Account or the Settlement, for the allocation, disbursement and payment of the Settlement Fund or Net Settlement Fund, or for the reviewing, challenging or determination of claims of Settlement Class Members. Co-Lead Counsel shall have the right, but not the obligation, to waive what they deem to be formal or technical defects in any Proofs of Claim submitted in the interests of achieving substantial justice.

18. For purposes of determining the extent, if any, to which a Settlement Class Member shall be entitled to be treated as an "Authorized Claimant", the following conditions shall apply:

(a) Each Settlement Class Member shall be required timely to submit a Proof of Claim (either in or substantially in the form of Exhibit 2 to Exhibit A), signed under penalty of

perjury and supported by such documents as are designated therein, including proof of Claimant's loss, or such other documents or proof as the Claims Administrator or Co-Lead Counsel, in their discretion, may deem acceptable.

(b) All Proofs of Claims must be submitted by the date specified in the Notice unless such period is extended by Order of the Court. Any Settlement Class Member who fails to submit a Proof of Claim by such date shall be forever barred from receiving any payment pursuant to this Stipulation (unless, by Order of the Court, a later submitted Proof of Claim by such Settlement Class Member is approved), but shall in all other respects be bound by all of the terms of this Stipulation and the Settlement, including the terms of the Judgment or Alternative Judgment to be entered in the Action and the releases provided for herein, and will be barred and enjoined from bringing any action against the Releasees concerning the Settled Claims. Provided that it is received before preparation of the distribution, a Proof of Claim shall be deemed to have been submitted when mailed, if received with a postmark indicated on the envelope and if mailed first-class postage prepaid and addressed in accordance with the instructions thereon. In all other cases, the Proof of Claim shall be deemed to have been submitted when actually received by the Claims Administrator;

(c) Each Proof of Claim shall be submitted to and reviewed by the Claims Administrator, under the supervision of Co-Lead Counsel, who shall determine in accordance with this Stipulation the extent, if any, to which each claim shall be allowed, subject to review by the Court pursuant to subparagraph (e) below;

(d) Proofs of Claim that do not meet the submission requirements may be rejected. Prior to rejection of a Proof of Claim, the Claims Administrator shall communicate with the Claimant in order to afford the Claimant the opportunity to remedy curable deficiencies

in the Proof of Claim submitted. The Claims Administrator, under the supervision of Co-Lead Counsel, shall notify, in a timely fashion and in writing, all Claimants whose Proofs of Claim it proposes to reject in whole or in part, setting forth the reasons therefore, and shall indicate in such notice that the Claimant whose claim is to be rejected has the right to a review by the Court if the Claimant so desires and complies with the requirements of subparagraph (e) below; and

(e) If any Claimant whose claim has been rejected in whole or in part desires to contest such rejection, the Claimant must, within twenty (20) calendar days after the date of mailing of the notice required in subparagraph (d) above, serve upon the Claims Administrator a notice and statement of reasons indicating the Claimant's grounds for contesting the rejection along with any supporting documentation, and requesting a review thereof by the Court. If a dispute concerning a claim cannot be otherwise resolved, Co-Lead Counsel shall thereafter present the request for review to the Court.

19. Each Claimant shall be deemed to have submitted to the jurisdiction of the Court with respect to the Claimant's claim, and the claim will be subject to investigation and discovery under the Federal Rules of Civil Procedure, provided that such investigation and discovery shall be limited to that Claimant's status as a Settlement Class Member and the validity and amount of the Claimant's claim. No discovery shall be allowed on the merits of the Action or the Settlement, including from any Defendant, for any reason.

20. Payment from the Settlement Fund pursuant to this Stipulation shall be deemed final and conclusive against all Settlement Class Members. All Settlement Class Members whose claims are not approved shall be barred from participating in distributions from the Net Settlement Fund, but otherwise shall be bound by all of the terms of this Stipulation and the Settlement, including the terms of the Judgment or Alternative Judgment to be entered in the

Action and the releases provided for herein, and will be barred and enjoined from bringing any action against the Releasees concerning the Settled Claims.

21. Any Settlement Class Member wishing to be excluded from the Settlement Class and this Settlement must timely mail a signed, written request for exclusion from the Settlement Class to the Claims Administrator, within the time and in accordance with the criteria and containing the information set forth in the Preliminary Approval Order and in the Notice. Unless amended by the Court, the Preliminary Approval Order, attached as Exhibit A hereto, shall provide that requests for exclusion shall be received no later than twenty-one (21) calendar days prior to the Settlement Hearing. Such Settlement Class Members who timely and validly exclude themselves from the Settlement Class shall not be bound by this Settlement and the releases described herein, shall have no entitlement to or claim upon all or any part of the Settlement Fund, and shall not receive any payment pursuant to the Settlement.

22. Co-Lead Counsel, subject to review by the Court, shall be responsible for determining whether a request for exclusion is timely and valid, in accordance with the criteria specified in the Court's Preliminary Approval Order and in the Notice. To be valid, a request for exclusion must comply fully with the criteria specified in the Preliminary Approval Order and in the Notice, and contain all of the information specified in Preliminary Approval Order and in the Notice. If a request for exclusion is untimely, or is invalid because it does not otherwise comply with the criteria or contain all of the information specified in the Court's Preliminary Approval Order and in the Notice, then it shall be void and of no effect, and that person or entity shall remain part of the Settlement Class in this Action and shall be bound by all of the terms of this Stipulation and the Settlement, including the terms of the Judgment or Alternative Judgment to be entered in the Action and the releases provided for herein, and will be barred and enjoined

from bringing any action against the Releasees concerning the Settled Claims. Any disputes regarding whether or not a request for exclusion is timely and valid, and thus effective, shall be resolved by the Court.

IX. FILING OF THE SECOND AMENDED COMPLAINT

23. As part of this Settlement, Lead Plaintiffs seek leave, pursuant to Federal Rule of Civil Procedure 15(a)(2), to file a Second Amended Complaint, in the form attached as Exhibit 4 to Exhibit A hereto, asserting substantially the same claims and seeking substantially the same relief as the Amended Complaint, on behalf of a putative class of purchasers of Chemed capital stock for an expanded class period of between February 15, 2010, and May 2, 2013, inclusive. That Second Amended Complaint includes, among other things, new allegations related to the complaint filed by the Department of Justice in the United States District Court for the Western District of Missouri, Western Division, titled *United States of America v. Vitas Hospice Services, L.L.C., et al.*, No. 4:13-cv-00449-BCN (W.D. Mo.).

24. Lead Plaintiffs provided a copy of the Second Amended Complaint attached as Exhibit 4 to Exhibit A hereto to Defendants prior to the execution of this Stipulation. As part of this Settlement, Defendants consent to Lead Plaintiffs' amendment of the Amended Complaint by filing the Second Amended Complaint. For the avoidance of doubt, and consistent with the definition of "Settled Claims" in Paragraph 1(ee) herein, the Settling Parties expressly confirm that all claims and allegations set forth in the Second Amended Complaint are included within the scope of (a) the Settled Claims that are being settled, resolved and dismissed, fully, finally and with prejudice, as part of this Settlement, and (b) the releases being provided by Releasors to Releasees as part of this Settlement.

X. TERMS OF PRELIMINARY APPROVAL ORDER

25. Promptly after this Stipulation has been fully executed, Co-Lead Counsel and Defendants' Counsel jointly shall apply to the Court for entry of a Preliminary Approval Order, substantially in the form annexed hereto as Exhibit A (with annexures). During the period from execution of this Stipulation to the Effective Date, which shall include the period following entry of the Preliminary Approval Order, each of the Settling Parties, and their respective heirs, executors, administrators, successors and assigns and all persons acting in concert with any such person or entity, agree not to institute, maintain or prosecute any or all Settled Claims or Settled Defendants' Claims against any or all of the Releasees or Lead Plaintiffs.

26. For the purposes of this Settlement only, Lead Plaintiffs and Defendants agree to (i) certification of the Action as a class action pursuant to Fed. R. Civ. P. 23(a) and 23(b)(3) on behalf of the Settlement Class as defined herein; (ii) appointment of Lead Plaintiffs as class representatives; and (iii) appointment of Co-Lead Counsel as class counsel pursuant to Fed. R. Civ. P. 23(g).

27. Defendants shall be responsible for providing any required notice under the Class Action Fairness Act of 2005.

XI. TERMS OF JUDGMENT

28. If the Settlement is approved by the Court, Co-Lead Counsel and Defendants' Counsel shall request that the Court enter a Judgment substantially in the form annexed hereto as Exhibit B (with annexure, if any).

XII. EFFECTIVE DATE OF SETTLEMENT

29. The Effective Date of this Settlement shall be the date when all of the following shall have occurred:

(a) entry of the Preliminary Approval Order substantially in the form annexed hereto as Exhibit A;

(b) payment of the Settlement Amount into the Escrow Account;

(c) approval by the Court of the Settlement, following notice to the Settlement Class and the Settlement Hearing, as prescribed by Rule 23 of the Federal Rules of Civil Procedure; and

(d) a Judgment substantially in the form set forth in Exhibit B annexed hereto, has been entered by the Court and has become Final, or, in the event that the Court enters a Alternative Judgment and none of the signatories hereto elects to terminate this Settlement, the date that such Alternative Judgment become Final.

XIII. TERMINATION

30. Defendants and Lead Plaintiffs shall have the right to terminate the Settlement and this Stipulation by providing written notice of their election to do so ("Termination Notice") to counsel for all other signatories hereto, within thirty (30) days of: (i) the Court's refusal to certify the Settlement Class as agreed by the Settling Parties in Paragraph 26 herein, or should any court amend the scope of the Settlement Class; (ii) the Court's refusal to enter the Preliminary Approval Order in any material respect; (iii) the Defendants' failure to cause the Settlement Amount to be deposited into the Escrow Account according to Paragraph 4 herein; (iv) the Court's refusal to approve this Stipulation or any material part of it; (v) the Court's refusal to enter the Judgment in any material respect; (vi) the date upon which the Judgment is modified or reversed in any material respect by the Court of Appeals or the Supreme Court; or (vii) the date upon which an Alternative Judgment is modified or reversed in any material respect by the Court of Appeals or Supreme Court.

31. In addition to the foregoing, Defendants shall also have the option, which must be exercised unanimously, to terminate the Settlement and this Stipulation, and render them null and void and of no further effect, in the event that Settlement Class Members who in total purchased or acquired in excess of a certain agreed-upon amount of Chemed capital stock during the Class Period (the "Termination Threshold") timely and validly request exclusion from the Settlement Class in accordance with the provisions of Paragraphs 21 and 22 herein, within the time and in accordance with the criteria set forth in the Preliminary Approval Order and in the Notice.

(a) The Settling Parties agree to maintain the confidentiality of the Termination Threshold, which is set forth in the Supplemental Agreement Regarding Requests for Exclusion ("Supplemental Agreement") that is simultaneously herewith being executed by Defendants' Counsel and Co-Lead Counsel. The Supplemental Agreement, unless otherwise ordered by the Court, shall be kept confidential and shall not be filed with the Court, but it may be examined in camera by the Court, if so requested.

(b) With respect to this Paragraph 31, no later than eighteen (18) calendar days prior to the Settlement Hearing, the Claims Administrator shall provide Defendants' Counsel with (i) copies of any and all requests for exclusion from the Settlement Class herein received by the Claims Administrator, (ii) a list of all persons or entities requesting exclusion, (iii) a list of shares of Chemed capital stock purchased or acquired during the Class Period by each of those persons or entities (to the extent provided to the Claims Administrator), (iv) a report by Co-Lead Counsel identifying which requests for exclusion they have determined to be timely and valid under the criteria specified in the Preliminary Approval Order and the Notice,

and (v) a representation, no later than eleven (11) calendar days prior to the Settlement Hearing, that all requests for exclusion received have been copied and provided to Defendants' Counsel.

(c) Defendants shall be entitled to exercise the option referenced in this Paragraph 31 to terminate the Settlement and this Stipulation only if they provide Co-Lead Counsel with written notice of Defendants' unanimous termination of the Settlement and file that notice with the Court no later than 5:00 p.m. Eastern time on the fourth (4th) business day prior to the Settlement Hearing.

(d) Co-Lead Counsel may attempt to cause the retraction of any request for exclusion by members of the Settlement Class prior to the Settlement Hearing. If Co-Lead Counsel succeed in causing the retraction of sufficient requests for exclusion such that the remaining requests for exclusion do not satisfy the requirements of the Termination Threshold, then Defendants' written notice of termination automatically shall be deemed a nullity. To retract a request for exclusion, a Settlement Class Member must, prior to the Settlement Hearing, file a written notice with the Court stating his, her, or its desire to retract the request for exclusion from the Settlement Class and that person or entity's desire to be bound by the Settlement, this Stipulation, and any Judgment entered herein, provided, however, that the filing of such written notice may be effected by Co-Lead Counsel.

(e) Any dispute among the Settling Parties concerning the interpretation or application of this Paragraph 31 and the Supplemental Agreement shall be presented to the Court for resolution upon the application of any party hereto.

32. If an option to terminate this Stipulation and Settlement arises under any of Paragraphs 30-31 above: (i) neither the Defendants nor Lead Plaintiffs (as the case may be) will be required for any reason or under any circumstance to exercise that option; and (ii) any

exercise of that option shall be made in good faith, but in the sole and unfettered discretion of the Defendants or Lead Plaintiffs, as applicable.

33. In the event the Settlement is terminated or any of the requirements of the "Effective Date" specified in Paragraph 29 are, for any reason, not satisfied, then the Settlement and this Stipulation shall be null and void, without prejudice, and none of its terms, including, but not limited to, the certification of the Settlement Class, the filing of the Second Amended Complaint, the appointment of Class Representatives, and the appointment of Class Counsel, shall be effective or enforceable, except that Paragraphs 33, 34, and 35 shall survive such termination; the Settling Parties shall be deemed to have reverted to their respective litigation positions in the Action immediately prior to September 16, 2013; and the Settling Parties in the Action shall proceed in all respects as if this Stipulation and any related orders had not been entered; neither Lead Plaintiffs nor any other putative Settlement Class Member may use the fact of execution of this Stipulation consenting to certification of a class solely for settlement purposes as a basis to argue that Defendants have in any way circumscribed, limited or waived their ability to oppose, for any reason, certification of a class other than for settlement purposes; and the fact and terms of the Settlement, this Stipulation and all settlement discussions shall not be admissible in any trial of this Action or any other proceeding, including, but not limited to, for the purposes of obtaining certification of a class other than for settlement purposes, and shall not be used by Lead Plaintiffs against or to the prejudice of the Defendants or by the Defendants against or to the prejudice of Lead Plaintiffs in any court filings, depositions, at trial, or otherwise.

34. In the event the Settlement is terminated or any of the requirements of the "Effective Date" specified in Paragraph 29 are, for any reason, not satisfied, then the Settlement

Amount previously paid on behalf of or by the Defendants, together with any interest and earnings thereon and including repayment of any attorneys' fees or expenses disbursed pursuant to Paragraph 6 herein (together with interest thereon), less any Taxes and/or Tax Expenses paid or due, and less any Notice and Administration Expenses actually incurred and paid or payable from the Settlement Fund pursuant to Paragraph 8 herein, shall be returned to the entity or entities that deposited the Settlement Amount into the Escrow Account on Defendants' behalf, within ten (10) business days after written notification of such event. At the request of Defendants, the Escrow Agent or its designee shall apply for any tax refund owed on the amounts in the Escrow Account and pay the proceeds, after any deduction of any fees or expenses incurred in connection with such application(s), for refund to the applicable funder or as otherwise directed.

XIV. NO ADMISSION OF WRONGDOING

35. This Stipulation, whether or not consummated, and any proceedings taken pursuant to it:

(a) shall not be offered or received against any Defendant or Releasee as evidence of, or construed as or deemed to be evidence of, any presumption, concession, or admission by any Defendant or Releasee with respect to the truth of any fact alleged by any of the plaintiffs or the validity of any claim that has been or could have been asserted in the Action or in any litigation, or the deficiency of any defense that has been or could have been asserted in the Action or in any litigation, or of any liability, negligence, fault or wrongdoing of any Defendant or Releasee;

(b) shall not be offered or received against any Defendant or Releasee as evidence of a presumption, concession or admission of any fault, misrepresentation or omission

with respect to any statement or written document approved or made by any Defendant or Releasee;

(c) shall not be offered or received against any Defendant or Releasee as evidence of a presumption, concession or admission with respect to any liability, negligence, fault or wrongdoing, or in any way referred to for any other reason as against any Defendant or Releasee, in any other civil, criminal or administrative action or proceeding, other than such proceedings as may be necessary to effectuate the provisions of this Stipulation; provided, however, that if this Stipulation is approved by the Court, the Settling Parties may refer to it to effectuate the liability protection granted them hereunder;

(d) shall not be construed against any Defendant or Releasee as an admission or concession that the consideration to be given hereunder represents the amount which could or would have been recovered after trial; and

(e) shall not be construed as or received in evidence as an admission, concession or presumption against Lead Plaintiffs or any of the Releasors that any of their claims are without merit, or that any defenses asserted by any Defendants have any merit, or that damages recoverable under the Complaint would not have exceeded the Settlement Amount or the Settlement Fund.

XV. PUBLICITY

36. Unless otherwise agreed upon or required by this Stipulation or law, the Settling Parties agree to treat the existence and terms of this Stipulation as confidential until Chemed publicly announces the Settlement. However, Defendants retain the right to disclose the existence and terms of this Stipulation to their external auditors and insurers at any time. Nothing herein shall preclude Co-Lead Counsel from identifying on their respective web sites and in any other materials describing their respective law firms, the fact that they were one of

Co-Lead Counsel in the Action and referring to the relief obtained pursuant to this Settlement upon its final approval.

37. In no event shall Lead Plaintiffs, Co-Lead Counsel, Defendants, or Defendants' Counsel make any public statement that disparages the business or reputation of any of the other Settling Parties, their counsel, or Releasees (including without limitation Chemed's subsidiary VITAS and its officers, directors, management and employees). Nothing in this provision prevents Co-Lead Counsel from (a) describing their role in this litigation in conversations with Settlement Class Members in the course of giving legal advice regarding the terms of the Settlement, or (b) making statements about Defendants in proceedings before the Court or any appellate court considering this Action.

XVI. MISCELLANEOUS PROVISIONS

38. All of the exhibits attached hereto are hereby incorporated by reference as though fully set forth herein.

39. The Settling Parties recognize that this Action was filed by Lead Plaintiffs and defended by Defendants in good faith, and neither Lead Plaintiffs, Defendants nor their respective counsel shall make any applications for sanctions pursuant to Rule 11 of the Federal Rules of Civil Procedure or other court rule or statute with respect to any claims or defenses asserted in this Action.

40. This Stipulation may not be modified or amended, nor may any of its provisions be waived except by a writing signed by all Settling Parties or their successors-in-interest.

41. The headings herein are used for the purpose of convenience only and are not meant to have legal effect.

42. The administration and consummation of the Settlement as embodied in this Stipulation shall be under the authority of the Court and the Court shall retain jurisdiction for the

purpose of entering orders providing for awards of attorneys' fees and expenses to Co-Lead Counsel and enforcing the terms of this Stipulation.

43. The waiver by one party of any breach of this Stipulation by any other party shall not be deemed a waiver of any other prior or subsequent breach of this Stipulation. Any such waiver shall be made on behalf of the party waiving the breach, and will not constitute a waiver by any other party.

44. This Stipulation and its exhibits constitute the entire agreement among the Settling Parties concerning the Settlement of the Action, and no representation, warranties, or inducements have been made by any party hereto concerning this Stipulation and its exhibits and other than those contained and memorialized in such documents.

45. This Stipulation may be executed in one or more counterparts, including by signature transmitted by facsimile or email. All executed counterparts and each of them shall be deemed to be one and the same instrument.

46. The Stipulation shall be binding upon, and inure to the benefit of, the successors and assigns of the Settling Parties.

47. The construction, interpretation, operation, effect and validity of this Stipulation and all documents necessary to effectuate it, shall be governed by the internal laws of the State of New York without regard to conflicts of laws, except to the extent that federal law requires that federal law governs.

48. This Stipulation shall not be construed more strictly against one party than another merely by virtue of the fact that it, or any part of it, may have been prepared initially by counsel for one of the Settling Parties, it being recognized that it is the result of arm's-length

negotiations between the Settling Parties and all Settling Parties have contributed substantially and materially to the preparation of this Stipulation.

49. All counsel and any other person executing this Stipulation and any of the exhibits hereto, or any related settlement documents, warrant and represent that they have the full authority to do so and that they have the authority to take appropriate action required or permitted to be taken pursuant to this Stipulation to effectuate its terms.

Dated February 6, 2014

ROBBINS GELLER RUDMAN & DOWD LLP

By:_____

Samuel H. Rudman
Evan J. Kaufman
Edward Y. Kroub
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LABATON SUCHAROW LLP

By:_____
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255 E. Fifth Street, Suite 1900
Cincinnati, OH 45202

Counsel for Defendants

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Counsel for Defendants

Exhibit A

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF OHIO
WESTERN DIVISION

In re CHEMED CORP. SECURITIES LITIGATION	No. 1:12-cv-00028-MRB

[PROPOSED] ORDER GRANTING PRELIMINARY APPROVAL OF CLASS ACTION SETTLEMENT, APPROVING FORM AND MANNER OF NOTICE, AND SETTING DATE FOR HEARING ON FINAL APPROVAL OF SETTLEMENT

WHEREAS, on February 6, 2014, the parties to the above-captioned action (the "Action") entered into a Stipulation and Agreement of Settlement (the "Stipulation") which is subject to review under Rule 23 of the Federal Rules of Civil Procedure and which, together with the exhibits thereto, sets forth the terms and conditions for the proposed settlement of claims asserted in the Action and in the Second Amended Complaint, dated February 6, 2014, (the "Complaint"), on the merits and with prejudice; and the Court having read and considered the Stipulation and the accompanying documents; and the parties to the Stipulation having consented to the entry of this Order; and all capitalized terms used herein having the meaning defined in the Stipulation;

NOW, THEREFORE, IT IS HEREBY ORDERED, this _____ day of _____, 2014 that:

1. The Court does hereby preliminarily approve the Stipulation and the Settlement set forth therein, as fair, reasonable and adequate, subject to further consideration at the Settlement Hearing described below.

2. Leave is granted, pursuant to Federal Rule of Civil Procedure 15(a)(2), for Plaintiffs to file a Second Amended Complaint in the form attached as Exhibit 4 to Exhibit A to

the Stipulation. That Second Amended Complaint shall henceforth, including for purposes of the Settlement, be the operative complaint in this Action. Plaintiffs shall file that Complaint within two (2) business days of this Order being so entered by the Court.

3. Pursuant to Rules 23(a) and (b)(3) of the Federal Rules of Civil Procedure, and for the purposes of the Settlement only, this Action is hereby certified as a class action on behalf of all persons or entities that purchased or otherwise acquired Chemed Corporation ("Chemed") capital stock during the period from February 15, 2010 through May 2, 2013, inclusive (the "Class Period"), and who were damaged thereby (the "Settlement Class"). Excluded from the Settlement Class are: (i) the Defendants; (ii) the officers and directors of Chemed, at any point during the Class Period; (iii) members of the immediate family of each of the Individual Defendants and the officers and directors of Chemed, at any point during the Class Period; (iv) any entity in which Defendants have or had a controlling interest; and (v) the legal representatives, heirs, predecessors, successors or assigns of any such excluded party. Also excluded from the Settlement Class are any putative Settlement Class Members who validly and timely exclude themselves from the Settlement Class.

4. The Court finds, for the purposes of the Settlement only, that the prerequisites for a class action under Rules 23(a) and 23(b)(3) of the Federal Rules of Civil Procedure have been satisfied in that: (i) the number of Settlement Class Members is so numerous that joinder of all members thereof is impracticable; (ii) there are questions of law and fact common to the Settlement Class; (iii) the claims of the named representatives are typical of the claims of the Settlement Class they seek to represent; (iv) Lead Plaintiffs and Co-Lead Counsel will fairly and adequately represent the interests of the Settlement Class; (v) the questions of law and fact common to the members of the Settlement Class predominate over any questions affecting only

individual members of the Settlement Class; and (vi) a class action is superior to other available methods for the fair and efficient adjudication of the controversy.

5. Pursuant to Rule 23 of the Federal Rules of Civil Procedure, and for the purposes of this Settlement only, Lead Plaintiffs, Electrical Workers Pension Fund, Local 103, I.B.E.W., and Greater Pennsylvania Carpenters Pension Fund, are certified as Class Representatives and Co-Lead Counsel Labaton Sucharow LLP and Robbins Geller Rudman & Dowd LLP are certified as Class Counsel.

6. A hearing (the "Settlement Hearing") pursuant to Rule 23(e) of the Federal Rules of Civil Procedure is hereby scheduled to be held before the Court on _____, 2014, at _____ for the following purposes:

(a) to finally determine whether this Action satisfies the applicable prerequisites for class action treatment under Rules 23(a) and (b) of the Federal Rules of Civil Procedure;

(b) to determine whether the proposed Settlement is fair, reasonable, and adequate, and should be approved by the Court;

(c) to determine whether the Judgment as provided for under the Stipulation should be entered, dismissing the Complaint filed herein on the merits and with prejudice, and to determine whether the release by the Releasors of the Settled Claims, as set forth in the Stipulation, should be provided to the Releasees;

(d) to determine whether the proposed Plan of Allocation for the proceeds of the Settlement is fair and reasonable, and should be approved by the Court;

(e) to consider Co-Lead Counsel's application for an award of attorneys' fees and expenses; and

(f) to rule upon such other matters at the Court may deem appropriate.

7. The Settlement Hearing may be adjourned by the Court without notice to the Settlement Class other than by an announcement of the adjournment at the scheduled time of the Settlement Hearing or at the scheduled time of any adjournment of the Settlement Hearing. The Court may consider modifications of the Settlement (with the consent of Lead Plaintiffs and Defendants) without further notice to the Settlement Class.

8. The Court reserves the right to approve the Settlement with or without modification and with or without further notice of any kind. The Court further reserves the right to enter its Judgment approving the Stipulation and dismissing the Complaint on the merits and with prejudice regardless of whether the Court has approved the Plan of Allocation or awarded attorneys' fees and expenses.

9. The Court approves the form, substance and requirements of the Notice of Pendency of Class Action and Proposed Settlement, Motion for Attorneys' Fees and Settlement Hearing (the "Notice") and the Proof of Claim form, annexed hereto as Exhibits 1 and 2 respectively.

10. The Court approves the appointment of Gilardi & Co. as the Claims Administrator. The Claims Administrator shall cause the Notice and Proof of Claim, substantially in the forms annexed hereto, to be mailed, by first class mail, postage prepaid, on or before ten (10) business days after the date of entry of this Order (the "Notice Date"), to all Settlement Class Members who can be identified with reasonable effort. In accordance with Paragraph 7 of the Stipulation, Chemed shall provide to the Claims Administrator, for the purpose of identifying and giving notice to the Settlement Class, information in electronic searchable format from Chemed's transfer records concerning the identity of potential Settlement

Class Members and their transactions in Chemed's capital stock during the Class Period. The Claims Administrator shall use reasonable efforts to give notice to nominee purchasers such as brokerage firms and other persons or entities who purchased Chemed's capital stock during the Class Period as record owners but not as beneficial owners. Such nominee purchasers are directed within seven (7) calendar days of their receipt of the Notice, (i) to provide the Claims Administrator with lists of the names and addresses of their beneficial owners, and the Claims Administrator is ordered to send the Notice and Proof of Claim forms promptly to such identified beneficial owners; or (ii) to request additional copies of the Notice and Proof of Claim form from the Claims Administrator and to mail the Notice and Proof of Claim forms directly to beneficial owners within seven (7) calendar days of receipt of such copies. Nominee purchasers who elect to send the Notice and Proof of Claim forms to their beneficial owners shall send a statement to the Claims Administrator confirming that the mailing was as directed. Additional copies of the Notice and Proof of Claim forms shall be made available to any record holder requesting such for the purpose of distribution to beneficial owners, and such record holders shall be reimbursed from the Settlement Fund, upon receipt by the Claims Administrator of proper documentation, for the reasonable and actual expense of sending the Notice and Proof of Claim forms to beneficial owners. Co-Lead Counsel shall, at or before the Settlement Hearing, file with the Court proof of mailing of the Notice and Proof of Claim forms.

11. The Court approves the Publication Notice of the pendency of this class action and the proposed Settlement in substantially the form and content annexed hereto as Exhibit 3 and directs Co-Lead Counsel to cause the Publication Notice to be published in *Investor's Business Daily* and to be transmitted over *Business Wire* within fourteen (14) calendar days of

the Notice Date. Co-Lead Counsel shall, at or before the Settlement Hearing, file with the Court proof of publication of the Publication Notice.

12. The form and content of the notices, and the method set forth herein of notifying the Settlement Class of the Settlement and its terms and conditions, meet the requirements of Rule 23 of the Federal Rules of Civil Procedure, Section 21D(a)(7) requirements of the Securities Exchange Act of 1934, 15 U.S.C. § 78u-4(a)(7) as amended by the Private Securities Litigation Reform Act of 1995, and due process, constitute the best notice practicable under the circumstances, and shall constitute due and sufficient notice to all persons and entities entitled thereto.

13. In order to be entitled to receive a distribution from the Net Settlement Fund, in the event the Settlement is effected in accordance with the terms and conditions set forth in the Stipulation, each Settlement Class Member shall take the following actions and be subject to the following conditions:

(a) To be valid, a properly executed Proof of Claim, substantially in the form attached hereto as Exhibit 2 and accompanied by all documents specified therein, must be submitted to the Claims Administrator, at the address indicated in the Notice, postmarked or received no later than 120 calendar days from the Notice Date. Such deadline may be further extended by Court Order. Each Proof of Claim shall be deemed to have been submitted when postmarked (if properly addressed and mailed by first class mail, postage prepaid), provided such Proof of Claim is actually received prior to the motion for an order of the Court approving distribution of the Net Settlement Fund. Any Proof of Claim submitted in any other manner shall be deemed to have been submitted when it was actually received at the address designated in the Notice.

(b) To be valid, the Proof of Claim submitted by each Settlement Class Member must satisfy the following conditions, unless otherwise ordered by the Court or allowed by Co-Lead Counsel in their discretion: (i) it must be properly completed, signed and submitted in a timely manner in accordance with the provisions of the preceding subparagraph; (ii) it must be accompanied by adequate supporting documentation for the transactions reported therein, in the form of broker confirmation slips, broker account statements, an authorized statement from the broker containing the transactional information found in a broker confirmation slip, or such other documentation as is deemed adequate by Co-Lead Counsel; (iii) if the person executing the Proof of Claim is acting in a representative capacity, a certification of his or her current authority to act on behalf of the Settlement Class Member must be included in the Proof of Claim; and (iv) the Proof of Claim must be complete and contain no material deletions or modifications of any of the printed matter contained therein and must be signed under penalty of perjury.

(c) As part of the Proof of Claim, each Settlement Class Member shall submit to the jurisdiction of the Court with respect to the claim submitted, and shall (subject to effectuation of the Settlement) release all Settled Claims against all Releasees as provided in the Stipulation.

14. Any member of the Settlement Class who does not submit a Proof of Claim form in the manner stated in this Order, unless otherwise ordered by the Court or allowed by Co-Lead Counsel in their discretion, shall be deemed to have waived his, her or its right to share in the Net Settlement Fund, and shall forever be barred from sharing in the Net Settlement Fund. Any such Settlement Class Member, however, in all other respects shall be subject to and bound by

all of the terms of the Settlement, including the terms of the Stipulation and the Judgment and the releases provided for by the Stipulation and the Judgment, unless such Settlement Class Member has timely submitted a valid request to be excluded from the Settlement Class in the manner required by this Order.

15. Any Settlement Class Member may enter an appearance in this Action, at his, her or its own expense, individually or through counsel of his, her or its own choice. If any Settlement Class Member does not enter an appearance, he, she or it will be represented by Co-Lead Counsel.

16. Settlement Class Members shall be bound by all determinations and judgments in this Action, whether favorable or unfavorable, unless such persons request exclusion from the Settlement Class in a timely and proper manner, as hereinafter provided. A Settlement Class Member wishing to make such request must mail the request in written form by first class mail to the address designated in the Notice such that it is received no later than twenty-one (21) calendar days before the Settlement Hearing. Such request must clearly indicate the name, address and telephone number of the person seeking exclusion, must clearly indicate that the sender requests to be "excluded from the Settlement Class in the *In re Chemed Corporation Securities Litigation*, No. 12-cv-028 (S.D. Ohio)," and must be signed by such person. Such persons requesting exclusion are also directed to state: the date(s), and corresponding price(s) and number(s) of shares, of all purchases and sales of Chemed capital stock during the Class Period.

17. Settlement Class Members who timely and validly exclude themselves from the Settlement Class shall not be entitled to receive any payment out of the Net Settlement Fund as described in the Stipulation and Notice.

18. Co-Lead Counsel shall submit their papers in support of final approval of the Settlement, the proposed Plan of Allocation and their application for attorneys' fees and expenses no later than thirty-five (35) calendar days before the Settlement Hearing. If reply papers are necessary, they are to be filed with the Court and served no later than seven (7) calendar days prior to the Settlement Hearing.

19. Any Settlement Class Member may be heard and/or appear at the Settlement Hearing to show cause why the proposed Settlement should not be approved as fair, reasonable and adequate and why the Judgment should not be entered thereon; why the proposed Plan of Allocation should not be approved as fair, reasonable, and adequate; or why Co-Lead Counsel should not be awarded attorneys' fees and payments of expenses in the amounts sought by Co-Lead Counsel; *provided, however*, that no Settlement Class Member shall be heard or be entitled to contest the approval of the terms and conditions of the proposed Settlement, the Judgment to be entered, the proposed Plan of Allocation or Co-Lead Counsel's application for an award of attorneys' fees and payment of expenses, unless on or before twenty-one (21) calendar days before the Settlement Hearing, the Settlement Class Member has filed objections, papers and briefs (showing due proof of service upon all below-listed counsel) with the Clerk of the Court, United States District Court for the Southern District of Ohio, Potter Stewart United States Courthouse, 100 East Fifth Street, Cincinnati, Ohio 45202, and has served by hand or by first-class mail written objections and copies of any supporting papers and briefs (which must contain proof of purchase of Chemed capital stock during the Class Period) upon:

Evan J. Kaufman
Robbins Geller Rudman & Dowd LLP
58 South Service Road, Suite 200
Melville, NY 11747

Jonathan Gardner
Labaton Sucharow LLP
140 Broadway, 34th Floor
New York, NY 10005

Co-Lead Counsel

Timothy G. Cameron
Cravath, Swaine & Moore LLP
Worldwide Plaza
825 Eighth Avenue
New York, NY 10019

Counsel for Defendants

Attendance at the hearing is not necessary; however, persons wishing to be heard orally in opposition to the approval of the Settlement, the proposed Plan of Allocation, and/or the request for attorneys' fees are required to indicate in their written objection their intention to appear at the hearing. Persons who intend to object to the Settlement, the proposed Plan of Allocation, and/or counsel's application for an award of attorneys' fees and expenses and desire to present evidence at the Settlement Hearing must include in their written objections the identity of any witnesses they may call to testify and exhibits they intend to introduce into evidence at the Settlement Hearing. Settlement Class Members do not need to appear at the hearing or take any other action to indicate their approval.

20. Any Settlement Class Member who does not object to the Settlement, the proposed Plan of Allocation, and/or Co-Lead Counsel's application for an award of attorneys' fees and expenses in the manner prescribed in this Order and in the Notice shall be deemed forever to have waived such objection and shall forever be barred from making any objection to the fairness, adequacy or reasonableness of the proposed Settlement, the Judgment to be entered approving the Settlement, the Plan of Allocation, and/or the application of Co-Lead Counsel for an award of attorneys' fees and expenses or from otherwise being heard concerning these subjects in this or any other proceeding.

21. Pending final determination of whether the Settlement should be approved, the Plaintiffs, all Settlement Class Members and Releasors, and each of them, and anyone who acts or purports to act on their behalf, are enjoined from initiating, continuing, filing or otherwise prosecuting any action which asserts any of the Settled Claims against any Releasees (including, without limitation, in any individual, class or putative class, representative or other action or proceeding), directly or indirectly, in any judicial, administrative, arbitral, or other forum between now and entry of the Judgment or termination of the Stipulation, whichever occurs earlier. This stay and injunction is necessary to protect and effectuate the Stipulation, and the Settlement, this Preliminary Approval Order, and the Court's flexibility and authority to effectuate the Stipulation and to enter the Judgment when appropriate, and is ordered in aid of the Court's jurisdiction and to protect its judgments. Pending the Settlement Hearing, the Court stays all proceedings in the Action, other than those proceedings necessary to carry out or enforce the terms and conditions of the Stipulation.

22. This Order, the Settlement, and any of their terms, and all negotiations, discussions and proceedings in connection with this Order and the Settlement, shall not constitute evidence, or an admission by any of the Defendants or the other Releasees, that any acts of wrongdoing have or have not been committed and shall not be deemed to create any inference that there is or is not any liability on the part of any of the Defendants or Releasees. This Order, the Settlement, and any of their terms, and all negotiations, discussions, and proceedings in connection with this Order and the Settlement, shall not be offered or received in evidence against Plaintiffs, Defendants, the Releasees, the Releasors, or their counsel, in this or any other proceeding in any court, administrative agency, arbitration tribunal, or other forum of

any kind or character in the United States or any other country except as necessary to enforce the terms of this Order and/or the Settlement.

23. As provided in the Stipulation, prior to the Effective Date of the Settlement, Co-Lead Counsel may reimburse the Claims Administrator up to $200,000 for the reasonable fees and costs associated with giving notice to the Settlement Class and the review of claims and administration of the Settlement out of the Settlement Fund without further order of the Court.

24. If any specified condition to the Settlement set forth in the Stipulation is not satisfied and Lead Plaintiffs or Defendants elect to terminate the Settlement as provided in Paragraphs 30 or 31 of the Stipulation, then, in any such event, the Stipulation, including any amendment(s) thereof, and this Preliminary Order certifying the Settlement Class, the Class Representatives and Class Counsel for the purpose of the Settlement shall be null and void, of no further force or effect, and without prejudice to any party, and may not be introduced as evidence or referred to in any actions or proceedings by any person or entity, and each party shall be restored to his, her or its respective position as it existed on September 16, 2013.

25. The Court retains exclusive jurisdiction over the Action to consider all further matters arising out of or connected with the Settlement.

Dated: _____, 2014.

_____
Honorable Michael R. Barrett
United States District Judge

Exhibit A-1

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF OHIO
WESTERN DIVISION

In re CHEMED CORP. SECURITIES LITIGATION	No. 1:12-cv-00028-MRB

NOTICE OF PENDENCY OF CLASS ACTION AND PROPOSED SETTLEMENT, MOTION FOR ATTORNEYS' FEES, AND SETTLEMENT HEARING

If you purchased Chemed Corporation ("Chemed") capital stock during the period from February 15, 2010 through May 2, 2013, inclusive (the "Class Period"), you could get a payment from a class action settlement.

A federal court authorized this Notice.[1] *This is not a solicitation from a lawyer.*

- Subject to the final approval of the Court, the parties to the above-captioned putative class action have reached an agreement to settle the case ("Settlement"). The Settlement will provide a $6 million settlement fund for the benefit of investors who bought Chemed capital stock during the Class Period – *i.e.*, between February 15, 2010 and May 2, 2013, inclusive.

- The Settlement resolves a lawsuit over whether Chemed and the other Defendants misled investors about certain of Chemed's business practices. Chemed and the other Defendants have denied, and continue to deny, those allegations, and this Settlement is not an admission of any kind of wrongdoing or liability by any of the Defendants.

- If you are a Settlement Class Member, your legal rights will be affected whether you act or do not act. Please read this Notice carefully.

[1] All capitalized terms not otherwise defined in this Notice have the meanings provided in the Stipulation and Agreement of Settlement executed by the parties to the above-captioned lawsuit, dated February 6, 2014 (the "Stipulation"). A copy of the Stipulation is available on the public docket of the United States District Court for the Southern District of Ohio, Western Division, under the above lawsuit caption, or at www.chemedsecuritiessettlement.com, www.labaton.com, and www.rgrdlaw.com.

YOUR LEGAL RIGHTS AND OPTIONS IN THIS SETTLEMENT:	
SUBMIT A CLAIM FORM BY _____, 2014	The only way to get a payment.
EXCLUDE YOURSELF FROM THE SETTLEMENT BY _____, 2014	Get no payment. This is the only option that allows you to ever be part of any other lawsuit against Chemed and the other Releasees involving any or all of the Settled Claims. (*See* Question ___, below.)
OBJECT BY _____, 2014	Write to the Court about why you do not like the Settlement, the proposed Plan of Allocation, and/or the request for attorneys' fees and expenses.
GO TO A HEARING ON _____, 2014 at ____:_____ ___.m.	Ask to speak in Court about the Settlement, the proposed Plan of Allocation, and/or the request for attorneys' fees and expenses.
DO NOTHING	Get no payment. If you are a Settlement Class Member, be bound by the Releases provided as part of this Settlement. Give up your rights.

- These rights and options – and the deadlines to exercise them – are explained in this Notice.

- The Court in charge of this case still has to decide whether to approve the Settlement. Payments will be made only if the Court approves the Settlement and after any appeals are resolved. Please be patient.

SUMMARY OF NOTICE

A. Statement of Plaintiffs' Recovery

Pursuant to the Settlement described in this Notice, a Settlement Fund consisting of Six Million U.S. Dollars ($6,000,000.00) in cash, plus any accrued interest, has been established. Lead Plaintiffs' consulting damages expert has estimated that there were approximately 9.7 million shares of Chemed capital stock traded during the Class Period that may have been damaged. Based on this estimate, the average recovery per allegedly damaged share of Chemed capital stock from the Settlement is $0.62 per share[2] before deduction of Court approved costs, such as attorneys' fees, litigation expenses, and administrative fees and expenses. A Settlement Class

[2] An allegedly damaged share might have been traded more than once during the Class Period, and the indicated average recovery would be the total for all purchasers of that share.

Member's actual recovery will be a portion of the Net Settlement Fund determined by comparing that Claimant's Recognized Claim (*see* page 7) to the total Recognized Claims of all Settlement Class Members who submit timely and valid Proofs of Claim. It will depend on the number of claims submitted, when during the Class Period a Settlement Class Member purchased Chemed capital stock, the purchase price paid, and whether those shares were held throughout or sold during the Class Period, and, if sold, when they were sold and the amount received. An individual Settlement Class Member may receive more or less than this average amount per share. *See* Plan of Allocation beginning on page 7.

B. Statement of Potential Outcome of Case

The Settling Parties disagree on both liability and damages and do not agree on the average amount of damages per share that would be recoverable if Plaintiffs were to have prevailed at trial on each claim alleged. The issues on which the Settling Parties disagree include (i) whether the statements made or facts allegedly omitted were material or otherwise actionable under the federal securities laws; (ii) the appropriate economic model for determining the amount by which Chemed's capital stock was allegedly artificially inflated (if at all) during the Class Period; (iii) the amount by which Chemed's capital stock was allegedly artificially inflated (if at all) during the Class Period; (iv) the effect of various market forces influencing the trading price of Chemed's capital stock at various times during the Class Period; (v) the extent to which external factors, such as general market and industry conditions, influenced the trading price of Chemed's capital stock during the Class Period; (vi) the extent to which the various matters that Plaintiffs alleged were materially false or misleading influenced (if at all) the trading price of Chemed's capital stock during the Class Period; and (vii) the extent to which the various allegedly adverse material facts that Plaintiffs alleged were omitted influenced (if at all) the trading price of Chemed's capital stock during the Class Period. The Defendants deny that they have violated any laws, deny that they are liable to Plaintiffs or the Settlement Class, deny that Plaintiffs or the Settlement Class have suffered any damages, and deny any and all contentions that Defendants' business, conduct and public statements constitute wrongdoing or give rise to legal liability of any kind or have caused damage.

C. Statement of Attorneys' Fees and Costs Sought

Co-Lead Counsel will ask the Court to award them attorneys' fees of no more than 33% of the Settlement Fund and litigation expenses of no more than $200,000, incurred in connection with the prosecution of this Action, which may include a request for an award to Lead Plaintiffs for reimbursement of their reasonable costs and expenses (including lost wages) directly related to their representation of the Settlement Class. The fee and expense request may include a request for interest, at the same rate and for the same periods as earned by the Settlement Fund. If the Court approves these requests, the fees and expenses would amount to an average cost of approximately $0.22 per allegedly damaged share.

The average cost per allegedly damaged share will vary depending on the number of timely and valid claims submitted. Co-Lead Counsel have expended considerable time and effort in the prosecution of this litigation without receiving any payment, and have advanced the expenses of the litigation, such as the cost of experts, in the expectation that if they were successful in obtaining a recovery they would be paid from such recovery. In this type of litigation, it is

customary for plaintiffs' counsel to be awarded a percentage of the common fund recovered as attorneys' fees.

D. Further Information

Further information regarding the Action and this Notice may be obtained by contacting Co-Lead Counsel or the Claims Administrator:

Co-Lead Counsel

Evan J. Kaufman
Robbins Geller Rudman & Dowd LLP
58 South Service Road, Suite 200
Melville, NY 11747
(800) 449-4900

Jonathan Gardner
Labaton Sucharow LLP
140 Broadway, 34th Floor
New York, NY 10005
(888) 219-6877

Claims Administrator

Chemed Securities Litigation
Claims Administrator
c/o Gilardi & Co. LLC
P.O. Box 990
Corte Madera, CA 94976-0990

PLEASE DO NOT CONTACT THE COURT OR COUNSEL FOR DEFENDANTS ABOUT THIS SETTLEMENT

E. Reasons for the Settlement

For Lead Plaintiffs, the principal reason for the Settlement is the immediate benefit to the Settlement Class. This benefit must be compared to the risk that no recovery might be achieved after a contested trial and likely appeals, possibly years into the future.

For the Defendants, who deny any and all liability whatsoever in connection with the Action and the Settled Claims, the principal reason for the Settlement is to limit further expense, inconvenience and distraction, to dispose of the burden of protracted litigation, and to permit the operation of Chemed's business without further distraction and diversion of Chemed's executives and other personnel with respect to the matters at issue in this Action.

BASIC INFORMATION

1. Why did I get this Notice?

You or someone in your family may have purchased Chemed capital stock during the period February 15, 2010 through May 2, 2013, inclusive.

The Court directed that this Notice be sent to Settlement Class Members because they have a right to know about a proposed settlement of this class action lawsuit, and about all their options, before the Court decides whether finally to approve the Settlement. If the Court approves the

Settlement, and after any objections and appeals are resolved, a claims administrator appointed by the Court will make the payments that the Settlement allows.

This package explains the lawsuit, the Settlement, Settlement Class Members' legal rights, what benefits are available, who is eligible for them, and how to get them.

The Court in charge of the case is the United States District Court for the Southern District of Ohio, Western Division. The case is known as *In re Chemed Corporation Securities Litigation*, File No. 1:12-cv-028. This case was assigned to United States District Judge Michael R. Barrett. The people who sued are called Plaintiffs, and the company and the people and entities they sued, namely, Chemed Corporation, Kevin McNamara, David Williams, and Timothy O'Toole, are called the Defendants.

2. What is this lawsuit about?

This is a federal securities fraud class action that is pending before Judge Michael R. Barrett in the United States District Court for the Southern District of Ohio.

Lead Plaintiffs are the Electrical Workers Pension Fund, Local 103, I.B.E.W., and the Greater Pennsylvania Carpenters Pension Fund.

Defendant Chemed, a Delaware corporation, is a Cincinnati-based corporation whose wholly owned subsidiary, VITAS Healthcare Corporation, is one of the nation's largest hospice providers.

The operative complaint in the Action, the Second Amended Complaint, dated February 6, 2014, (the "Complaint"), alleges that Lead Plaintiffs and other Settlement Class Members purchased the capital stock of Chemed at prices artificially inflated as a result of the Defendants' alleged dissemination of allegedly materially false or misleading statements. The Complaint asserts claims under Sections 10(b) and 20(a) of the Securities Exchange Act of 1934 (the "Exchange Act") and Rule 10b-5 promulgated thereunder.

The Defendants deny any and all liability or wrongdoing whatsoever in connection with the claims asserted in the Action as well as all claims that that could have been asserted by Lead Plaintiffs or Settlement Class Members in connection with the purchase or acquisition of Chemed's capital stock during the Class Period.

With the assistance of former Vice Chancellor of Delaware Court of Chancery Stephen Lamb acting as a mediator, Lead Plaintiffs, by their counsel, conducted lengthy discussions and arm's length negotiations with counsel for Defendants on September 16, 2013, with a view to achieving a compromise and settlement of this Action and all issues in dispute between them, and achieving the best relief possible consistent with the best interests of the Settlement Class.

Based upon their investigation, consultation with experts, and the assistance of the mediator, Co-Lead Counsel have concluded that the terms and conditions of the Settlement are fair, reasonable and adequate to Lead Plaintiffs and the Settlement Class, and in their best interests, and have agreed to settle the claims raised in the Action pursuant to the terms and provisions of the Stipulation, after considering (i) the substantial benefits that Lead Plaintiffs and the members of

the Settlement Class will receive from settlement of the Action, (ii) the attendant risks of litigation, and (iii) the desirability of permitting the Settlement to be consummated as provided by the terms of the Stipulation.

3. Why is this a class action?

In a class action, one or more people called class representatives (in this case the Electrical Workers Pension Fund, Local 103, I.B.E.W. and the Greater Pennsylvania Carpenters Pension Fund), sue on behalf of people who have similar claims. All these people together are a class or class members. Bringing a case, such as this one, as a class action allows the adjudication of many similar claims of different persons and entities that might be economically too small to bring in individual actions. One court resolves the issues for all class members, except those who exclude themselves from the class.

4. Why is there a Settlement?

The Court has not decided the case in favor of either Plaintiffs or Defendants. Instead, both sides, with the assistance of former Vice Chancellor Lamb acting as a mediator, have agreed to the Settlement. That way, Plaintiffs avoid the risks and cost of a trial, and the people affected will get compensation. Defendants also avoid the continuing costs, burdens and distractions of litigation. The Class Representatives and their attorneys think the Settlement is best for the Settlement Class.

WHO IS IN THE SETTLEMENT

To see if you will get any money from this Settlement, you first have to determine if you are a Settlement Class Member.

5. How do I know if I am part of the Settlement?

The Court directed, for the purpose of the proposed Settlement, that everyone who fits the following description is a Settlement Class Member: all persons or entities that purchased or otherwise acquired Chemed capital stock during the period from February 15, 2010 through May 2, 2013, inclusive, and who were damaged thereby.

6. Are there exceptions to being included in the Settlement Class?

Excluded from the Settlement Class are: (i) the Defendants; (ii) the officers and directors of Chemed, at any point during the Class Period; (iii) members of the immediate family of each of the Individual Defendants and the officers and directors of Chemed, at any point during the Class Period; (iv) any entity in which Defendants have or had a controlling interest; and (v) the legal representatives, heirs, predecessors, successors or assigns of any such excluded party. Also excluded from the Settlement Class are any putative Settlement Class Members who validly exclude themselves from the Settlement Class by timely filing a request for exclusion in accordance with the requirements set forth in this Notice.

If one of your mutual funds purchased shares of Chemed capital stock during the Class Period, that alone does not make you a Settlement Class Member. You are a Settlement Class Member

only if you directly purchased shares of Chemed capital stock during the Class Period. Check your investment records or contact your broker to see if you purchased Chemed capital stock during the Class Period.

If you **sold** Chemed capital stock during the Class Period, that alone does not make you a Settlement Class Member. You are a Settlement Class Member only if you **purchased** or otherwise acquired your shares during the Class Period.

7. What if I am still not sure if I am included?

If you are still not sure whether you are included, you can ask for free help. You can call [•] or visit www.chemedsecuritiessettlement.com for more information. Or you can fill out and return the Proof of Claim form described on page 12, in Question 11, to see if you qualify.

THE SETTLEMENT BENEFITS – WHAT YOU GET

8. What does the Settlement provide?

In exchange for the Settlement and a dismissal with prejudice of the Action, the Defendants and their insurers have agreed to create a $6 million fund to be divided, after deduction of attorneys' fees and expenses, settlement administration fees and expenses, and any applicable Taxes (the "Net Settlement Fund"), among all Settlement Class Members who timely send in valid Proof of Claim forms. Neither Defendants nor their insurers shall be liable for or required to pay to any member of the Settlement Class or Co-Lead Counsel any amount in excess of that $6 million fund.

9. How much will my payment be?

Your share of the Net Settlement Fund will depend on several things, including: (i) the total amount of Recognized Losses (*see* Question 10) of other Settlement Class Members; (ii) how many shares of Chemed capital stock you purchased; (iii) how much you paid for your shares; (iv) when you bought them; and (v) whether or when you sold your shares, and, if so, for how much.

Your Recognized Loss will be calculated according to the formula shown below in the Plan of Allocation (*see* Question 10). It is unlikely that you will get a payment for all of your Recognized Loss. After all Settlement Class Members have sent in their Proof of Claim forms, the payment you get will be a *pro rata* portion of the Net Settlement Fund based on your Recognized Loss divided by the total of everyone's Recognized Losses. *See* the Plan of Allocation below for more information on your Recognized Loss.

PLAN OF ALLOCATION OF NET SETTLEMENT FUND

10. How will my claim be calculated?

The purpose of the Plan of Allocation is to distribute settlement proceeds equitably to those Settlement Class Members who suffered economic losses resulting from the alleged misrepresentations and omissions by Defendants during the Class Period. The Court may

approve the Plan of Allocation or modify it without additional notice to the Settlement Class. Any order modifying the Plan of Allocation will be posted at www.chemedsecuritiessettlement.com, www.labaton.com, and www. rgrdlaw.com.[3]

The $6,000,000 Settlement Amount and any interest earned thereon following its funding shall be the Settlement Fund. The Settlement Fund, less all Taxes, approved costs, fees and expenses (the "Net Settlement Fund") shall be distributed to members of the Settlement Class who timely submit valid Proofs of Claim ("Authorized Claimants"). Settlement Class Members who do not submit valid Proofs of Claim will not share in the Settlement proceeds but will otherwise be bound by the terms of the Settlement, including the Releases provided to Defendants, and the Judgment entered by the Court.

The Claims Administrator shall determine each Authorized Claimant's *pro rata* share of the Net Settlement Fund based upon each Authorized Claimant's "Recognized Loss." The Recognized Loss formula is not intended to estimate the amount a Settlement Class Member might have been able to recover after trial; nor does it estimate the amount that will be paid to Authorized Claimants pursuant to the Settlement. The Recognized Loss formula is the basis upon which the Net Settlement Fund will be proportionately allocated to the Authorized Claimants. No distributions to Authorized Claimants who would receive less than $10.00 will be made, given the administrative expenses of processing and mailing such checks.

Payment pursuant to the Plan of Allocation, or such other plan as may be approved by the Court, shall be final and conclusive against all Authorized Claimants. The Defendants, their respective counsel, and all other Releasees will have no responsibility for or liability whatsoever for the investment of the Settlement Fund, the distribution of the Net Settlement Fund, the Plan of Allocation or the payment of any claim. Lead Plaintiffs and Co-Lead Counsel likewise will have no liability for their reasonable efforts to execute, administer, and distribute the Settlement.

The proposed Plan of Allocation reflects Lead Plaintiffs' contention – disputed by Defendants – that the price of Chemed capital stock was artificially inflated throughout the Class Period, but that parts of the inflation were removed upon various disclosures being revealed. The Defendants deny that contention and any and all allegations of wrongdoing or liability. Neither this Plan of Allocation – which was prepared by Lead Plaintiffs and Co-Lead Counsel – nor the discussion of it that follows constitutes an admission of any kind of wrongdoing or liability by any of the Defendants. Defendants and their counsel and insurers do not, and are not required to, endorse or approve this Plan of Allocation, or the methods of calculation discussed below.

General Principles of the Plan of Allocation

The Plan of Allocation recognizes and compensates Authorized Claimants for losses allegedly caused by two disclosures of information made during Class Period that allegedly relate to Lead

[3] Defendants had no involvement in preparing the proposed Plan of Allocation, and will have no involvement in its implementation. Defendants bear no responsibility or liability whatsoever for the allocation, distribution, use or administration of the Settlement Fund.

Plaintiffs' allegations in the Action. First, on November 16, 2011, Bloomberg News published an article regarding a whistleblower lawsuit filed by a former VITAS employee in San Antonio, Texas. After adjusting for general equity market and comparable industry security price changes on November 16, 2011, Lead Plaintiffs' damages consultant concluded that this alleged disclosure removed $5.96 per share of alleged artificial stock price inflation at that time.

Second, after the close of trading on May 2, 2013, the Department of Justice announced that the federal government filed a lawsuit against Chemed and various wholly owned hospice subsidiaries, including Vitas Hospice Services LLC and Vitas Healthcare Corp., alleging false Medicare billings. After adjusting for general equity market and comparable industry security price changes on November 16, 2011, Lead Plaintiffs' damages consultant concluded that this alleged disclosure removed $13.97 per share of artificial stock price inflation at that time.

As described in the Plan of Allocation, no Recognized Loss shall be recognized for shares that were purchased and resold within the periods: (a) February 16, 2010 through November 15, 2011; and (b) November 16, 2011 through May 2, 2013. The Plan of Allocation also precludes a recovery for losses that are unrelated to the fraud alleged in the Action.

As provided for in the Private Securities Litigation Reform Act of 1995 ("PSLRA"), the Plan of Allocation limits Recognized Losses based on the price levels of Chemed capital stock during the 90-day "lookback period" following each disclosure discussed above.

If any of the calculations below result in a negative number, (*e.g.*, a claimant's purchase price was less than a claimant's sales price under para. 1C(2)(a) or a claimant's purchase price was less than the average closing price of Chemed capital stock between November 16, 2011 and the date of sale under para. 1C(2)(b)), that negative figure shall constitute a Recognized Gain. In addition, for shares purchased and resold within the periods: (a) February 16, 2010 through November 15, 2011; and (b) November 16, 2011 through May 2, 2013, if a claimant's purchase price was less than claimant's sales price, that negative figure shall constitute a Recognized Gain. The sum of any Recognized Gains will be used to offset the sum of any Recognized Losses.

Calculation of Recognized Loss Amounts

1. For shares of Chemed capital stock purchased or otherwise acquired between February 16, 2010 and November 15, 2011:

   A. For shares held at the end of trading on February 13, 2012 (90 days after the first corrective disclosure on November 15, 2011) [4], the Recognized Loss shall be the number of shares held on that date multiplied by the lesser of:

[4] Pursuant to Section 21(D)(e)(1) of the PSLRA, "in any private action arising under this title in which the plaintiff seeks to establish damages by reference to the market price of a security, the award of damages to the plaintiff shall not exceed the difference between the purchase or sale price paid or received, as appropriate, by the plaintiff for the subject security and the mean trading price of that security during the 90-day period beginning on the date on

(1) $5.96 per share; or
(2) the difference between the purchase price per share and $53.25.

B. For shares sold between February 16, 2010 and November 15, 2011, there shall be no Recognized Loss.

C. For shares sold between November 16, 2011 and February 13, 2012, the Recognized Loss shall be the lesser of:

(1) $5.96 per share; or
(2) the lesser of (a) the difference between the purchase price per share and the sales price per share; or (b) the difference between the purchase price per share and the average closing price of Chemed capital stock between November 16, 2011 and the date of sale.[5]

2. For shares of Chemed capital stock purchased or otherwise acquired between November 16, 2011 and May 2, 2013:

A. For shares held at the end of trading on July 31, 2013 (90 days after the second corrective disclosure on May 2, 2013)[6], the Recognized Loss shall be the number of shares held on that date multiplied by the lesser of:

(1) $13.97 per share; or
(2) the difference between the purchase price per share and $71.11.

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which the information correcting the misstatement or omission that is the basis for the action is disseminated." $53.25 was the mean closing price of Chemed capital stock during the 90-day period beginning on November 16, 2011 and ending on February 13, 2012.

[5] Pursuant to Section 21(D)(e)(2) of the PSLRA, "in any private action arising under this title in which the plaintiff seeks to establish damages by reference to the market price of a security, if the plaintiff sells or repurchases the subject security prior to the expiration of the 90-day period described in paragraph (1), the plaintiff's damages shall not exceed the difference between the purchase or sale price paid or received, as appropriate, by the plaintiff for the security and the mean trading price of the security during the period beginning immediately after dissemination of information correcting the misstatement or omission and ending on the date on which the plaintiff sells or repurchases the security." The average closing price of Chemed capital stock between November 16, 2011 and each trading date through February 13, 2012 is found on Table A.

[6] *See* footnote 4 for an explanation of the relevant statutory provision. $71.11 was the mean closing price of Chemed capital stock during the 90-day period beginning on May 3, 2013 and ending on July 31, 2013.

B. For shares sold between November 16, 2011 and May 2, 2013, there shall be no Recognized Loss.

C. For shares sold between May 3, 2013 and July 31, 2013, the Recognized Loss shall be the lesser of:

(1) $13.97 per share; or
(2) the lesser of (a) the difference between the purchase price per share and the sales price per share; or (b) the difference between the purchase price per share and the average closing price of Chemed capital stock between May 3, 2013 and the date of sale.[7]

Additional Principles

For purposes of determining whether a Claimant has a Recognized Loss, purchases, acquisitions, and sales of Chemed capital stock will be matched on a First In/First Out ("FIFO") basis. If a Claimant has more than one purchase/acquisition or sale of Chemed capital stock during the Class Period, all purchases/acquisitions and sales of Chemed capital stock shall be matched using FIFO. Class Period sales will be matched first against any holdings at the beginning of the Class Period, and then against purchases/acquisitions in chronological order, beginning with the earliest purchase/acquisitions made during the Class Period.

The receipt or grant by gift, inheritance, or operation of law of Chemed capital stock during the Class Period shall not be deemed a purchase, acquisition, or sale of such security for the calculation of a Claimant's Recognized Loss.

To the extent there are sufficient funds in the Net Settlement Fund, each Authorized Claimant will receive an amount equal to the Authorized Claimant's Recognized Loss. If, however, the amounts in the Net Settlement Fund are not sufficient to permit payment of the total of all Recognized Losses, then each Authorized Claimant will be paid the percentage of the Net Settlement Fund that each Authorized Claimant's recognized claim bears to the total of the claims of all Authorized Claimants ("*pro rata* share").

If the funds remaining in the Settlement Fund following *pro rata* distribution(s) to all Authorized Claimants are an amount that is not cost effective or efficient to redistribute to Authorized Claimants, then such remaining funds, after payment of any further Notice and Administration Expenses, Taxes and Tax Expenses, shall be contributed to the Legal Aid Society of Greater Cincinnati, a non-sectarian, not-for-profit, 501(c)(3) organization.

[7] *See* footnote 5 for an explanation of the relevant statutory provision. The average closing price of Chemed capital stock between May 3, 2013 and each trading date through July 31, 2013 is found on Table A.

HOW YOU GET A PAYMENT – SUBMITTING A PROOF OF CLAIM FORM

11. How can I get a payment?

To qualify for a payment, you must timely submit a valid Proof of Claim form. A Proof of Claim form is being circulated with this Notice. You may also get a Proof of Claim form on the internet at www.chemedsecuritiessettlement.com. Read the instructions carefully, fill out the Proof of Claim Form, include copies of all the documents the form asks for, sign it, and mail it, together with all necessary documents, **postmarked or received no later than [DATE]**, to:

Chemed Corporation Securities Litigation Claims

Claims Administrator
c/o Gilardi & Co. LLC
P.O. Box 990
Corte Madera, CA 94976-0990

12. When would I get my payment?

The Court will hold a hearing on __:___ _.m. on _____ ___, 2014, to decide whether to approve the Settlement. If the Court approves the Settlement, after that there may also be appeals. It is always uncertain whether and when these appeals can be resolved, and resolving them can take time, perhaps more than a year. It also takes time for all the Proofs of Claim to be processed. Please be patient.

13. What am I giving up to get a payment or by staying in the Settlement Class?

If you are a Settlement Class Member, then, unless you exclude yourself, you are staying in the Settlement Class and that means that, upon the "Effective Date" of the Settlement, you will release all "Settled Claims" (as defined below) against the "Releasees" (as defined below), fully and finally, and with prejudice.

"Settled Claims" means any and all claims (including any claim that the Stipulation was fraudulently induced), debts, demands, rights, actions, suits, causes of action or liabilities whatsoever (including, but not limited to, any and all claims for damages, interest, attorneys' fees, expert or consulting fees, and any other costs, expenses or liability whatsoever), whether based on federal, state, local, statutory, or common law, or any other law, rule or regulation (whether foreign or domestic), whether class or individual in nature, including both known claims and Unknown Claims, (i) that have been asserted in this Action by or on behalf of the Settlement Class Members or any of them against any of the Releasees (including without limitation all claims and allegations in the Complaint, the Amended Complaint and/or the Second Amended Complaint), or (ii) that could have been asserted in any forum by or on behalf of the Releasors now or in the future, or any of them, against any of the Releasees or Defendants' Counsel that relate to, or that in any way arise out of, or are based upon, the allegations, transactions, facts, matters or occurrences, acts, disclosures, statements, representations, omissions, or failures to act involved, set forth, or referred to in any of the complaints or

proposed complaints filed in this Action, including but not limited to the Complaint, the Amended Complaint and/or the Second Amended Complaint, and that relate to the purchase, acquisition, or sale of the capital stock of Chemed during the Class Period. For the avoidance of doubt, Settled Claims do not include: (i) claims to enforce the Settlement; (ii) *KBC Asset Management NV, et al. v. Kevin J. McNamara, et al.*, No. 13-cv-01854-UNA (D. Del.); (iii) *North, et al. v. Kevin J. McNamara, et al.*, No. 1:13-cv-00833-MRB (S.D. Ohio); and (iv) any governmental or regulatory agency's claims in, or any right to relief from, any criminal or civil action against any of the Releasees.

"Releasees" refers jointly and severally, individually and collectively to Individual Defendants, Chemed, and its past, present, and future direct and indirect parents, subsidiaries, divisions and affiliates, and their respective present and former officers, directors, employees, managers, agents, insurers, attorneys and legal representatives, and the predecessors, successors, heirs, executors, trustees, administrators and assigns of each of the foregoing. As used in this Paragraph, "affiliates" means entities controlling, controlled by or under common control with Chemed. The Releasees are express third-party beneficiaries of the Stipulation and Agreement of Settlement.

"Unknown Claims" means any and all Settled Claims which any Lead Plaintiff or Releasor does not know or suspect to exist in his, her or its favor at the time the release of the Releasees, and any Settled Defendants' Claims which any Defendant or Releasee does not know or suspect to exist in his, her or its favor, which if known by him, her or it might have affected his, her or its decision(s) with respect to the Settlement. With respect to any and all Settled Claims and Settled Defendants' Claims, the Settling Parties stipulate and agree that upon the Effective Date, the Lead Plaintiffs and the Defendants shall expressly waive, and each Releasor and Releasee shall be deemed to have waived, and by operation of the Judgment or Alternative Judgment shall have expressly waived, any and all provisions, rights and benefits of conferred by any law of any state or territory of the United States, or principle of common law, which is similar comparable, or equivalent to Cal. Civ. Code § 1542, which provides:

> A GENERAL RELEASE DOES NOT EXTEND TO CLAIMS WHICH THE CREDITOR DOES NOT KNOW OR SUSPECT TO EXIST IN HIS OR HER FAVOR AT THE TIME OF EXECUTING THE RELEASE, WHICH IF KNOWN BY HIM OR HER MUST HAVE MATERIALLY AFFECTED HIS OR HER SETTLEMENT WITH THE DEBTOR.

Releasors may hereafter discover facts in addition to or different from those which he, she, or it now knows or believes to be true with respect to the subject matter of the Settled Claims, but each of them hereby stipulates and agrees that the Lead Plaintiffs, and each Releasor shall be deemed to settle and release, and upon the Effective Date and by operation of the Judgment or Alternative Judgment shall have settled and released, fully, finally, and forever, and all Settled Claims against Releasees, known or unknown, suspected or unsuspected, contingent or non-contingent, whether or not concealed or hidden, which now exist, or which heretofore existed upon any theory of law or equity now existing or coming into existence in the future, including, but not limited to, conduct that is negligent or intentional and with or without malice, or a breach

of any duty, law, or rule, without regard to the subsequent discovery or existence of such different or additional facts. Similarly, Defendants may hereafter discover facts in addition to or different from those which he, she, or it now knows or believes to be true with respect to the subject matter of Settled Defendants' Claims, but each of them hereby stipulates and agrees that Defendants, and Releasees shall be deemed upon the Effective Date and by operation of the Judgment or Alternative Judgment, to have fully, finally, and forever settled and released any and all Settled Defendants' Claims against Releasors, known or unknown, suspected or unsuspected contingent or non-contingent, whether or not concealed or hidden, which now exist, or heretofore have existed upon any theory of law or equity now existing or coming into existence in the future, including, but not limited to, conduct which is negligent, intentional, with or without malice, or a breach of any duty, law, or rule, without regard to the subsequent discovery or existence of such different or additional facts. Lead Plaintiffs and Defendants acknowledge, and all other Releasors and Releasees by operation of law shall be deemed to have acknowledged, that the inclusion of "Unknown Claims" in the definition of Settled Claims and Settled Defendants' Claims was separately bargained for and was a key element of the Settlement.

The "Effective Date" of the Settlement will occur when an Order by the Court approving the Settlement becomes Final and is not subject to appeal, as set out more fully in the Stipulation. The Stipulation is on file with the Court and available at www.chemedsecuritiessettlement.com, www.labaton.com, and www.rgrdlaw.com.

If you are a Settlement Class Member and you stay in the Settlement Class, all of the Court's orders will apply to you and will legally bind you.

EXCLUDING YOURSELF FROM THE SETTLEMENT

If you do not want a payment from this Settlement, and you want to keep any right you may have to sue or continue to sue the Defendants and the other Releasees on your own in connection with any part of the Settled Claims, then you must take steps to exclude yourself from the Settlement Class. This is called "opting out" or seeking exclusion from the Settlement Class. Defendants may withdraw from and terminate the Settlement if Settlement Class Members who purchased in excess of a certain amount of Chemed capital stock exclude themselves from the Settlement Class.

14. How do I get out of the proposed Settlement?

To exclude yourself from the Settlement Class, you must send a written, signed letter by mail stating that you request to be "excluded from the Settlement Class in *In re Chemed Corporation Securities Litigation*, File No. 1:12-cv-028 (S.D. Ohio)." Your letter must state: the date(s), and corresponding price(s) and number(s) of shares, of all purchases and sales of Chemed capital stock you made during the Class Period. In addition, you must include your name, address, telephone number, and your signature. You must mail your written, signed exclusion request so that it is **received at the following address no later than [DATE]**:

Chemed Corporation Securities Litigation Exclusions
Chemed Securities Litigation
Claims Administrator
c/o Gilardi & Co. LLC
P.O. Box ___
Corte Madera, CA 94976-0990

You cannot exclude yourself from the Settlement Class by telephone or by e-mail. Any attempt to do so will be ineffective and invalid. Also, your request for exclusion from the Settlement Class will be invalid if either (1) you fail to provide all of the information specified above, or (2) it is not received at the above address by the date specified.

If you ask to be excluded, you will not get any settlement payment, and you cannot object to the Settlement. You will not be legally bound by anything that happens in this lawsuit, and you may be able to sue (or continue to sue) the Defendants and the other Releasees individually in the future.

15. If I do not exclude myself, can I sue the Defendants and the other Releasees for the same thing later?

No. Unless you exclude yourself, you give up any rights to sue the Defendants and the other Releasees for any and all Settled Claims. **If you have a pending lawsuit, speak to your lawyer in that case immediately.** You **must** exclude yourself from *this* Settlement Class to continue your own lawsuit. Remember, the exclusion deadline is **[DATE]**.

16. If I exclude myself, can I get money from the proposed Settlement?

No. If you exclude yourself, do not send in a Proof of Claim form to ask for any money. But you may exercise any right you may have to sue, continue to sue, or be part of any different lawsuit against the Defendants and the other Releasees.

THE LAWYERS REPRESENTING THE SETTLEMENT CLASS

17. Do I have a lawyer in this case?

The Court ordered that the law firms below represent the Settlement Class. These lawyers are called Co-Lead Counsel. You will not be separately charged for these lawyers and the services they provide. The Court will determine the amount of Co-Lead Counsel's fees and expenses, which will be paid from the Settlement Fund. If you want to be represented by your own lawyer, you may hire one at your own expense.

Samuel H. Rudman
Evan J. Kaufman
Edward Y. Kroub
Robbins Gellar Rudman & Dowd LLP
58 South Service Road, Suite 200
Melville, NY 11747
(800) 449-4900

Jonathan Gardner
Mark S. Goldman
Carol C. Villegas
Labaton Sucharow LLP
140 Broadway, 34th Floor
New York, NY 10005
(888) 219-6877

18. How will the lawyers be paid?

At the Settlement Hearing, or at such other time as the Court may order, Co-Lead Counsel will ask the Court to award them, from the Settlement Fund, attorneys' fees of no more than 33% of the Settlement Fund, plus any interest on such amount at the same rate as earned by the Settlement Fund, and litigation expenses (such as the cost of experts) that have been incurred in pursuing the Action, which may include the costs and expenses (including lost wages) of Lead Plaintiffs. The request for litigation expenses will not exceed $200,000, plus interest on the expenses at the same rate as may be earned by the Settlement Fund.

OBJECTING TO THE SETTLEMENT

You can tell the Court that you do not agree with the Settlement or some part of it.

19. How do I tell the Court that I do not like the proposed Settlement?

If you are a Settlement Class Member you can object to the Settlement or any of its terms, the proposed Plan of Allocation, and/or the application by Co-Lead Counsel for an award of attorneys' fees and expenses. You may write to the Court explaining your objection. You may give reasons why you think the Court should not approve any or all of the Settlement terms or arrangements. The Court will consider your views if you file a proper objection within the deadline and according to the following procedures:

To object, you must send a signed letter stating that you object to the proposed Settlement in *In re Chemed Corporation Securities Litigation*, File No. 1:12-cv-028 (S.D. Ohio). You must include your name, address, telephone number, and your signature; identify : the date(s), and corresponding price(s) and number(s) of shares, of all purchases and sales of Chemed capital stock you made during the Class Period; and state the reasons why you object to the Settlement. Your objection must be filed with the Court and mailed to all the following counsel no later than [DATE]:

COURT	CO-LEAD COUNSEL DESIGNEES	DEFENDANTS' COUNSEL DESIGNEE
Clerk of the Court United States District Court Southern District of Ohio Western Division Potter Stewart United States Courthouse 100 East Fifth Street Cincinnati, Ohio 45202	Evan J. Kaufman Robbins Geller Rudman & Dowd LLP 58 South Service Road, Suite 200 Melville, NY 11747 Jonathan Gardner Labaton Sucharow LLP 140 Broadway, 34th Floor New York, NY 10005	Timothy G. Cameron Cravath, Swaine & Moore LLP Worldwide Plaza 825 Eighth Avenue New York, NY 10019

You do not need to go to the Settlement Hearing to have your written objection considered by the Court. If you want to speak at the Settlement Hearing, any Settlement Class Member who has not previously submitted a request for exclusion from the Settlement Class and who has

complied with the procedures set out in this Question and Question 23 below may also appear and be heard, to the extent allowed by the Court, concerning the Settlement, the Plan of Allocation, or Co-Lead Counsel's motion for an award of attorneys' fees and reimbursement of expenses. Any such objector may appear in person or arrange, at that objector's expense, for a lawyer to represent them at the Settlement Hearing.

20. What is the difference between objecting and seeking exclusion?

Objecting is simply telling the Court that you do not like something about the proposed Settlement. You can object only if you remain in the Settlement Class. Excluding yourself is telling the Court that you do not want to be part of the Settlement Class. If you exclude yourself, you have no basis to object because the case no longer affects you.

THE COURT'S SETTLEMENT HEARING

The Court will hold a hearing to decide whether to approve the proposed Settlement. You may attend and you may ask to speak, but you do not have to do either.

21. When and where will the Court decide whether to approve the proposed Settlement?

The Court will hold the Settlement Hearing at __:___ _.m. on _____ ___, 2014, at the United States District Court, Southern District of Ohio, Western Division, Potter Stewart United States Courthouse, 100 East Fifth Street, Cincinnati, Ohio 45202. At this hearing the Court will consider whether the Settlement is fair, reasonable, and adequate. At the hearing, the Court will also consider the proposed Plan of Allocation for the proceeds of the Settlement and the application of Co-Lead Counsel for attorneys' fees and payment of expenses. The Court will take into consideration any written objections filed in accordance with the instructions at Question 19. The Court also may listen to people who have properly indicated an intention to speak at the hearing, but decisions regarding the conduct of the hearing will be made by the Court. *See* Question 23 for more information about speaking at the hearing. After the hearing, the Court will decide whether to approve the Settlement. We do not know how long these decisions will take.

You should be aware that the Court may change the date and time of the Settlement Hearing. If you want to come to the hearing, you should check with Co-Lead Counsel beforehand to be sure that the date and/or time has not changed.

22. Do I have to come to the hearing?

No. Co-Lead Counsel will answer questions the Court may have. But you are welcome to come at your own expense. If you send an objection, you do not have to come to Court to talk about it. As long as you filed your written objection on time, the Court will consider it. You may also pay your own lawyer to attend, but it is not necessary. Settlement Class Members do not need to appear at the hearing or take any other action to indicate their approval.

23. May I speak at the hearing?

If you object to the Settlement, you may ask the Court for permission to speak at the Settlement Hearing. To do so, you must include with your objection (*see* Question 19 above) a statement that it is your "Notice of Intention to Appear in the *In re Chemed Corporation Securities Litigation*, File No. 1:12-cv-028 (S.D. Ohio)." Persons who intend to object to the Settlement, the Plan of Allocation, and/or counsel's application for an award of attorneys' fees and expenses and desire to present evidence at the hearing must include in their written objections the identity of any witnesses they may call to testify and exhibits they intend to introduce into evidence at the Settlement Hearing. Unless otherwise ordered by the Court, you cannot speak at the Settlement Hearing if you have excluded yourself from the Settlement Class or if you have not provided written notice of your objection and intention to speak at the hearing in accordance with the procedures described in Questions 19 and 23.

IF YOU DO NOTHING

24. What happens if I do nothing at all?

If you do nothing, you will get no money from this Settlement and you will be precluded from starting a lawsuit, continuing with a lawsuit, or being part of any other lawsuit against Defendants and other Releasees about the Settled Claims in this case, ever again. To share in the Net Settlement Fund you must submit a Proof of Claim form (*see* Question 11). To start, continue or to be part of any other lawsuit against the Defendants and the other Releasees about the Settled Claims in this case, you must exclude yourself from this Settlement Class (*see* Question 14).

GETTING MORE INFORMATION

25. Are there more details about the proposed Settlement?

This Notice summarizes the proposed Settlement. More details are in the Stipulation. You can get a copy of the Stipulation by writing to any one of Co-Lead Counsel, or by visiting www.chemedsecuritiessettlement.com, www.labaton.com, www.rgrdlaw.com.

You can also call the Claims Administrator at [●] toll free; write to the Claims Administrator at *Chemed Securities Litigation*, c/o Gilardi & Co. LLC, P.O. Box 990, Corte Madera, CA 94976-0990; or visit www.chemedsecuritiessettlement.com where you will find answers to common questions about the Settlement, a Proof of Claim form, and other information to help you determine whether you are a Settlement Class Member and whether you are eligible for a payment.

26. How do I get more information?

For even more detailed information concerning the matters involved in this Action, you may refer to the pleading, to the Stipulation, to the Orders entered by the Court and to the other papers filed in the Action, which may be inspected during regular business hours at the Office of the Clerk of the United States District Court, Southern District of Ohio, Western Division, Potter Stewart United States Courthouse, 100 East Fifth Street, Cincinnati, Ohio 45202.

SPECIAL NOTICE TO SECURITIES BROKERS AND OTHER NOMINEES

If you purchased Chemed capital stock during the period from February 15, 2010 through May 2, 2013, inclusive, (the "Class Period") for the beneficial interest of a person or organization other than yourself, the Court has directed that WITHIN SEVEN (7) DAYS OF YOUR RECEIPT OF THIS NOTICE, you either (i) provide the Claims Administrator the name and last known address of each person or organization for whom or which you purchased Chemed capital stock during the Class Period or (ii) request additional copies of this Notice and the Proof of Claim form, which will be provided to you free of charge, and within seven (7) days of receipt mail the Notice and Proof of Claim form directly to the beneficial owners of that Chemed capital stock. If you choose to follow alternative procedure (ii), the Court has directed that, upon such mailing, you must send a statement to the Claims Administrator confirming that the mailing was made as directed. You are entitled to reimbursement from the Settlement Fund of your reasonable expenses actually incurred in connection with the foregoing, including reimbursement of postage expense and the cost of ascertaining the names and addresses of beneficial owners. Those expenses will be paid upon request and submission of appropriate supporting documentation. All communications concerning the foregoing should be addressed to the Claims Administrator:

In re Chemed Corporation Securities Litigation
Claims Administrator
c/o Gilardi & Co. LLC
P.O. Box ____
Corte Madera, CA 94976-0990

Dated: Cincinnati, Ohio
_____, 2014

BY ORDER OF THE COURT

TABLE A

Chemed Corporation Common Stock
Calculation of Average Closing Price During 90 Day Periods Following Corrective Disclosures

Date	Closing Price	Average Closing Price 11/16/2011 Through Date	Date	Closing Price	Average Closing Price 05/03/2013 Through Date
11/16/2011	$ 50.65	$ 50.65	5/3/2013	$ 68.00	$ 68.00
11/17/2011	$ 50.00	$ 50.33	5/6/2013	$ 68.78	$ 68.39
11/18/2011	$ 49.77	$ 50.14	5/7/2013	$ 68.17	$ 68.32
11/21/2011	$ 49.95	$ 50.09	5/8/2013	$ 67.52	$ 68.12
11/22/2011	$ 49.82	$ 50.04	5/9/2013	$ 67.08	$ 67.91
11/23/2011	$ 50.00	$ 50.03	5/10/2013	$ 63.90	$ 67.24
11/25/2011	$ 49.83	$ 50.00	5/13/2013	$ 64.87	$ 66.90
11/28/2011	$ 51.33	$ 50.17	5/14/2013	$ 65.87	$ 66.77
11/29/2011	$ 51.39	$ 50.30	5/15/2013	$ 66.49	$ 66.74
11/30/2011	$ 53.66	$ 50.64	5/16/2013	$ 66.67	$ 66.74
12/1/2011	$ 54.36	$ 50.98	5/17/2013	$ 68.18	$ 66.87
12/2/2011	$ 53.29	$ 51.17	5/20/2013	$ 68.33	$ 66.99
12/5/2011	$ 53.36	$ 51.34	5/21/2013	$ 68.54	$ 67.11
12/6/2011	$ 50.52	$ 51.28	5/22/2013	$ 67.69	$ 67.15
12/7/2011	$ 51.13	$ 51.27	5/23/2013	$ 67.73	$ 67.19
12/8/2011	$ 49.55	$ 51.16	5/24/2013	$ 68.27	$ 67.26
12/9/2011	$ 50.20	$ 51.11	5/28/2013	$ 68.45	$ 67.33
12/12/2011	$ 49.96	$ 51.04	5/29/2013	$ 68.38	$ 67.38
12/13/2011	$ 48.24	$ 50.90	5/30/2013	$ 69.10	$ 67.47
12/14/2011	$ 49.43	$ 50.82	5/31/2013	$ 70.02	$ 67.60
12/15/2011	$ 50.05	$ 50.79	6/3/2013	$ 70.87	$ 67.76
12/16/2011	$ 50.05	$ 50.75	6/4/2013	$ 70.49	$ 67.88
12/19/2011	$ 49.39	$ 50.69	6/5/2013	$ 70.65	$ 68.00
12/20/2011	$ 50.79	$ 50.70	6/6/2013	$ 71.00	$ 68.13
12/21/2011	$ 51.32	$ 50.72	6/7/2013	$ 71.78	$ 68.27
12/22/2011	$ 52.30	$ 50.78	6/10/2013	$ 72.13	$ 68.42
12/23/2011	$ 52.04	$ 50.83	6/11/2013	$ 71.46	$ 68.53
12/27/2011	$ 52.49	$ 50.89	6/12/2013	$ 72.00	$ 68.66

12/28/2011	$	51.24	$	50.90	6/13/2013	$	72.83	$	68.80
12/29/2011	$	51.91	$	50.93	6/14/2013	$	72.53	$	68.93
12/30/2011	$	51.21	$	50.94	6/17/2013	$	72.86	$	69.05
1/3/2012	$	52.38	$	50.99	6/18/2013	$	74.02	$	69.21
1/4/2012	$	51.18	$	50.99	6/19/2013	$	73.71	$	69.34
1/5/2012	$	51.34	$	51.00	6/20/2013	$	73.16	$	69.46
1/6/2012	$	51.98	$	51.03	6/21/2013	$	73.50	$	69.57
1/9/2012	$	53.34	$	51.10	6/24/2013	$	73.02	$	69.67
1/10/2012	$	53.19	$	51.15	6/25/2013	$	73.43	$	69.77
1/11/2012	$	53.60	$	51.22	6/26/2013	$	74.44	$	69.89
1/12/2012	$	52.75	$	51.26	6/27/2013	$	73.16	$	69.98
1/13/2012	$	53.77	$	51.32	6/28/2013	$	72.43	$	70.04
1/17/2012	$	54.13	$	51.39	7/1/2013	$	73.13	$	70.11
1/18/2012	$	55.10	$	51.48	7/2/2013	$	72.95	$	70.18
1/19/2012	$	55.39	$	51.57	7/3/2013	$	73.06	$	70.25
1/20/2012	$	56.70	$	51.68	7/5/2013	$	73.97	$	70.33
1/23/2012	$	57.22	$	51.81	7/8/2013	$	74.25	$	70.42
1/24/2012	$	57.53	$	51.93	7/9/2013	$	73.50	$	70.49
1/25/2012	$	58.03	$	52.06	7/10/2013	$	73.80	$	70.56
1/26/2012	$	57.23	$	52.17	7/11/2013	$	74.09	$	70.63
1/27/2012	$	57.24	$	52.27	7/12/2013	$	75.34	$	70.73
1/30/2012	$	56.49	$	52.36	7/15/2013	$	75.64	$	70.82
1/31/2012	$	56.14	$	52.43	7/16/2013	$	75.88	$	70.92
2/1/2012	$	57.28	$	52.52	7/17/2013	$	74.74	$	71.00
2/2/2012	$	58.29	$	52.63	7/18/2013	$	75.03	$	71.07
2/3/2012	$	58.74	$	52.75	7/19/2013	$	69.26	$	71.04
2/6/2012	$	57.91	$	52.84	7/22/2013	$	70.16	$	71.02
2/7/2012	$	57.99	$	52.93	7/23/2013	$	71.56	$	71.03
2/8/2012	$	58.42	$	53.03	7/24/2013	$	71.35	$	71.04
2/9/2012	$	57.69	$	53.11	7/25/2013	$	71.46	$	71.05
2/10/2012	$	57.44	$	53.18	7/26/2013	$	72.87	$	71.08
2/13/2012	$	57.24	$	53.25	7/29/2013	$	72.02	$	71.09
					7/30/2013	$	72.82	$	71.12
					7/31/2013	$	70.59	$	71.11

Exhibit A-2

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF OHIO
WESTERN DIVISION

In re CHEMED CORP. SECURITIES LITIGATION	No. 1:12-cv-00028-MRB

PROOF OF CLAIM AND RELEASE

I. GENERAL INSTRUCTIONS

1. To recover as a member of the Settlement Class based on your claims in the action entitled *In re Chemed Corp. Securities Litig.*, No. 1:12-cv-00028-MRB (S.D. Ohio) (the "Action"), you must complete and, on page __ below, sign this Proof of Claim and Release. If you fail to submit a properly addressed (as set forth in paragraph 3 below) Proof of Claim and Release, postmarked or received by the date shown below, your claim may be rejected and you may be precluded from any recovery from the Net Settlement Fund created in connection with the proposed Settlement of the Action.

2. Submission of this Proof of Claim and Release, however, does not assure that you will share in the proceeds of the Settlement of the Action.

3. YOU MUST MAIL OR SUBMIT YOUR COMPLETED AND SIGNED PROOF OF CLAIM AND RELEASE, ACCOMPANIED BY COPIES OF THE DOCUMENTS REQUESTED HEREIN, **NO LATER THAN _____, 2014 TO THE COURT-APPOINTED CLAIMS ADMINISTRATOR IN THIS CASE, AT THE FOLLOWING ADDRESS**:

Chemed Securities Litigation
Claims Administrator
c/o Gilardi & Co. LLC
P.O. Box 990
Corte Madera, CA 94976-0990
www.chemedsecuritiessettlement.com

If you are NOT a member of the Settlement Class (as defined in the Notice of Pendency of Class Action and Proposed Settlement, Motion for Attorneys' Fees, and Settlement Hearing (the "Notice")), DO NOT submit a Proof of Claim and Release.

4. If you are a member of the Settlement Class and you do not timely request exclusion in connection with the proposed Settlement, you will be bound by the terms of any judgment entered in the Action, including the releases provided therein, WHETHER OR NOT YOU SUBMIT A PROOF OF CLAIM AND RELEASE.

II. CLAIMANT IDENTIFICATION

1. If you purchased the capital stock of Chemed Corporation ("Chemed" or the "Company") during the period from February 15, 2010 through and including May 2, 2013, and held the capital stock in your name, you are the beneficial purchaser as well as the record purchaser. If, however, you purchased Chemed capital stock that was registered in the name of a third party, such as a nominee or brokerage firm, you are the beneficial purchaser and the third party is the record purchaser.

2. Use Part I of this form entitled "Claimant Identification" to identify each purchaser of record ("nominee"), if different from the beneficial purchaser of the capital stock which form the basis of this claim. THIS CLAIM MUST BE FILED BY THE ACTUAL BENEFICIAL PURCHASER(S) OR THE LEGAL REPRESENTATIVE OF SUCH PURCHASER(S) OF THE CHEMED CAPITAL STOCK UPON WHICH THIS CLAIM IS BASED.

3. All joint purchasers must sign this claim. Executors, administrators, guardians, conservators and trustees must complete and sign this claim on behalf of persons represented by them and their authority must accompany this claim and their titles or capacities must be stated. The Social Security (or taxpayer identification) number and telephone number of the beneficial owner

may be used in verifying the claim. Failure to provide the foregoing information could delay verification of your claim or result in rejection of the claim.

4. If you are acting in a representative capacity on behalf of a Settlement Class Member (for example, as an executor, administrator, trustee, or other representative), you must submit evidence of your current authority to act on behalf of that Settlement Class Member. Such evidence may include, for example, letters testamentary, letters of administration, or a copy of the trust documents.

5. NOTICE REGARDING ELECTRONIC FILES: Certain claimants with large numbers of transactions may request to, or may be requested to, submit information regarding their transactions in electronic files. All claimants MUST submit a manually signed paper Proof of Claim and Release listing all their transactions whether or not they also submit electronic copies. If you wish to file your claim electronically, you must contact the Claims Administrator at 1-877-567-4781 to obtain the required file layout. No electronic files will be considered to have been properly submitted unless the Claims Administrator issues to the claimant a written acknowledgement of receipt and acceptance of electronically submitted data.

III. CLAIM FORM & SUPPORTING DOCUMENTATION

1. Use Part II of this form entitled "Schedule of Transactions in Chemed Capital Stock" to supply all required details of your transaction(s) in Chemed capital stock. If you need more space or additional schedules, attach separate sheets giving all of the required information in substantially the same form. Sign and print or type your name on each additional sheet.

2. On the schedules, provide all of the requested information with respect to ***all*** of your purchases and ***all*** of your sales of Chemed capital stock during the period from February 15, 2010 through May 2, 2013, inclusive, regardless of whether or not such transactions resulted in a profit or a loss. You must also provide all of the requested information with respect to ***all*** of the Chemed

capital stock you held at the close of trading on February 14, 2010, May 2, 2013, and July 31, 2013. Failure to report all such transactions may result in the rejection of your claim.

3. List these transactions separately and in chronological order, by trade date, beginning with the earliest. You must accurately provide the month, day and year of each transaction you list. For short-sale transactions, the date of covering a "short sale" is deemed to be the date of purchase of Chemed capital stock, and the date of a "short sale" is deemed to be the date of sale of Chemed capital stock.

4. For each transaction, you must provide, together with your Claim Form copies of stockbroker confirmation slips, stockbroker statements, or other documents evidencing your transactions in Chemed capital stock. If any such documents are not in your possession, you must obtain a copy or equivalent documents from your broker because these documents are necessary to prove and process your claim. Failure to provide this documentation could delay verification of your claim or result in rejection of your claim.

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF OHIO
WESTERN DIVISION
In re Chemed Corp. Securities Litigation

No. 1:12-cv-00028-MRB
PROOF OF CLAIM AND RELEASE
Must Be Postmarked or Received No Later Than:
_____, 2014

Please Type or Print

I: CLAIMANT IDENTIFICATION

_____
Beneficial Owner's Name (First, Middle, Last)

_____
Street Address

_____ _____
City State or Province

_____ _____
Zip Code or Postal Code Country

_____ Individual
_____ Corporation/Other
Social Security Number or
Taxpayer Identification Number

_____ _____
Area Code Telephone Number (work)

_____ _____
Area Code Telephone Number (home)

_____
Record Owner's Name (if different from beneficial owner listed above)

II: SCHEDULE OF TRANSACTIONS IN CHEMED CAPITAL STOCK

A. Number of shares of Chemed capital stock held at the close of trading on February 14, 2010: _____.

B. Purchases of Chemed capital stock between February 15, 2010 and July 31, 2013, inclusive:

Trade Date Mo. Day Year	Number of Shares Purchased	Total Purchase Price
1. _____ 2. _____ 3. _____	1. _____ 2. _____ 3. _____	1. _____ 2. _____ 3. _____

IMPORTANT: Identify by number listed above all purchases in which you covered a "short sale": _____

C. Sales of Chemed capital stock between February 15, 2010 and May 2, 2013, inclusive:

Trade Date Mo. Day Year	Number of Shares Sold	Total Sales Price
1. _____ 2. _____ 3. _____	1. _____ 2. _____ 3. _____	1. _____ 2. _____ 3. _____

D. Sales of Chemed capital stock between May 2, 2013 and July 31, 2013, inclusive:

Trade Date Mo. Day Year	Number of Shares Sold	Total Sales Price
1. _____ 2. _____ 3. _____	1. _____ 2. _____ 3. _____	1. _____ 2. _____ 3. _____

E. Number of shares of Chemed capital stock held at the close of trading on May 2, 2013: _____.

F. Number of shares of Chemed capital stock held at the close of trading on July 31, 2013: _____.

If you require additional space, attach extra schedules in the same format as above. Sign and print your name on each additional page. **PLEASE NOTE: YOUR SIGNATURE ON PAGE ___ BELOW WILL CONSTITUTE YOUR ACKNOWLEDGMENT OF THE RELEASE DESCRIBED IN PART IV BELOW**.

III. SUBMISSION TO JURISDICTION OF COURT AND ACKNOWLEDGMENTS

I (We) submit this Proof of Claim and Release under the terms of the Stipulation and Agreement of Settlement ("Stipulation") described in the accompanying Notice. I (We) also submit to the jurisdiction of the United States District Court for the Southern District of Ohio, Western Division, with respect to my (our) claim as a Settlement Class Member and for purposes of enforcing the release set forth herein. I (We) further acknowledge that I am (we are) bound by and subject to the terms of any judgment that may be entered in the Action. I (We) agree to furnish additional information to the Claims Administrator to support this claim if requested to do so. I (We) have not submitted any other claim in connection with the purchase of Chemed capital stock and know of no other person having done so on my (our) behalf.

IV. RELEASE

1. I (We) hereby acknowledge full and complete satisfaction of, and do hereby fully, finally and forever settle, release and discharge from the Settled Claims each and all of the Releasees as provided in the Stipulation.

2. "Releasees" refers jointly and severally, individually and collectively to Individual Defendants, Chemed, and its past, present, and future direct and indirect parents, subsidiaries, divisions and affiliates, and their respective present and former officers, directors, employees, managers, agents, insurers, attorneys and legal representatives, and the predecessors, successors, heirs, executors, trustees, administrators and assigns of each of the foregoing. As used in this Paragraph, "affiliates" means entities controlling, controlled by or under common control with

Chemed. The Releasees are express third-party beneficiaries of the Stipulation and Agreement of Settlement.

3. "Releasors" refers jointly and severally, individually and collectively, to Lead Plaintiffs and all Settlement Class Members, and their past, present and future direct and indirect parents, subsidiaries, divisions and affiliates, and their respective present and former officers, directors, employees, managers, agents, attorneys and legal representatives, and the predecessors, successors, heirs, executors, trustees, administrators and assigns of each of the foregoing. As used in this Paragraph, "affiliates" means entities controlling, controlled by or under common control with Releasors.

4. "Settled Claims" means any and all claims (including any claim that this Stipulation was fraudulently induced), debts, demands, rights, actions, suits, causes of action or liabilities whatsoever (including, but not limited to, any and all claims for damages, interest, attorneys' fees, expert or consulting fees, and any other costs, expenses or liability whatsoever), whether based on federal, state, local, statutory, or common law, or any other law, rule or regulation (whether foreign or domestic), whether class or individual in nature, including both known claims and Unknown Claims, (i) that have been asserted in this Action by or on behalf of the Settlement Class Members or any of them against any of the Releasees (including without limitation all claims and allegations in the Complaint, the Amended Complaint and/or the Second Amended Complaint), or (ii) that could have been asserted in any forum by or on behalf of the Releasors now or in the future, or any of them, against any of the Releasees or Defendants' Counsel that relate to, or that in any way arise out of, or are based upon, the allegations, transactions, facts, matters or occurrences, acts, disclosures, statements, representations, omissions, or failures to act involved, set forth, or referred to in any of the complaints or proposed complaints filed in this Action, including but not limited to the Complaint, the Amended Complaint and/or the Second Amended Complaint, and that relate to the

purchase, acquisition, or sale of the capital stock of Chemed during the Class Period. For the avoidance of doubt, Settled Claims do not include: (i) claims to enforce the Settlement; (ii) *KBC Asset Management NV, et al. v. Kevin J. McNamara, et al.*, No. 13-cv-01854-UNA (D. Del.); (iii) *North, et al. v. Kevin J. McNamara, et al.*, No. 1:13-cv-00833-MRB (S.D. Ohio); and (iv) any governmental or regulatory agency's claims in, or any right to relief from, any criminal or civil action against any of the Releasees..

5. "Unknown Claims" means any and all Settled Claims which any Lead Plaintiff or Releasor does not know or suspect to exist in his, her or its favor at the time the release of the Releasees, and any Settled Defendants' Claims which any Defendant or Releasee does not know or suspect to exist in his, her or its favor, which if known by him, her or it might have affected his, her or its decision(s) with respect to the Settlement. With respect to any and all Settled Claims and Settled Defendants' Claims, the Settling Parties stipulate and agree that upon the Effective Date, the Lead Plaintiffs and the Defendants shall expressly waive, and each Releasor and Releasee shall be deemed to have waived, and by operation of the Judgment or Alternative Judgment shall have expressly waived, any and all provisions, rights and benefits of conferred by any law of any state or territory of the United States, or principle of common law, which is similar comparable, or equivalent to Cal. Civ. Code § 1542, which provides:

> A GENERAL RELEASE DOES NOT EXTEND TO CLAIMS WHICH THE CREDITOR DOES NOT KNOW OR SUSPECT TO EXIST IN HIS OR HER FAVOR AT THE TIME OF EXECUTING THE RELEASE, WHICH IF KNOWN BY HIM OR HER MUST HAVE MATERIALLY AFFECTED HIS OR HER SETTLEMENT WITH THE DEBTOR.

Releasors may hereafter discover facts in addition to or different from those which he, she, or it now knows or believes to be true with respect to the subject matter of the Settled Claims, but each of them hereby stipulates and agrees that the Lead Plaintiffs, and each Releasor shall be deemed to settle and release, and upon the Effective Date and by operation of the Judgment or Alternative

Judgment shall have settled and released, fully, finally, and forever, and all Settled Claims against Releasees, known or unknown, suspected or unsuspected, contingent or non-contingent, whether or not concealed or hidden, which now exist, or which heretofore existed upon any theory of law or equity now existing or coming into existence in the future, including, but not limited to, conduct that is negligent or intentional and with or without malice, or a breach of any duty, law, or rule, without regard to the subsequent discovery or existence of such different or additional facts. Similarly, Defendants may hereafter discover facts in addition to or different from those which he, she, or it now knows or believes to be true with respect to the subject matter of Settled Defendants' Claims, but each of them hereby stipulates and agrees that Defendants, and Releasees shall be deemed upon the Effective Date and by operation of the Judgment or Alternative Judgment, to have fully, finally, and forever settled and released any and all Settled Defendants' Claims against Releasors, known or unknown, suspected or unsuspected contingent or non-contingent, whether or not concealed or hidden, which now exist, or heretofore have existed upon any theory of law or equity now existing or coming into existence in the future, including, but not limited to, conduct which is negligent, intentional, with or without malice, or a breach of any duty, law, or rule, without regard to the subsequent discovery or existence of such different or additional facts. Lead Plaintiffs and Defendants acknowledge, and all other Releasors and Releasees by operation of law shall be deemed to have acknowledged, that the inclusion of "Unknown Claims" in the definition of Settled Claims and Settled Defendants' Claims was separately bargained for and was a key element of the Settlement.

6. This release shall be of no force or effect unless and until the Court approves the Settlement Agreement and the Settlement becomes effective on the Effective Date.

7. I (We) hereby warrant and represent that I (we) have not assigned or transferred or purported to assign or transfer, voluntarily or involuntarily, any matter released pursuant to this release or any other part or portion thereof.

8. I (We) hereby warrant and represent that I (we) have included information about all of my (our) purchases and sales of Chemed capital stock from February 15, 2010 through July 31, 2013, inclusive, and the number of Chemed capital stock held by me (us) at the close of trading on February 14, 2010, May 2, 2013, and July 31, 2013.

9. I (We) certify that I am (we are) not subject to backup withholding under the provisions of Section 3406(a)(1)(C) of the Internal Revenue Code.

Note: If you have been notified by the Internal Revenue Service that you are subject to backup withholding, please strike out the language that you are not subject to backup withholding in the certification above.

I declare under penalty of perjury under the laws of the United States of America that the foregoing information supplied by the undersigned is true and correct.

Executed this _____ day of _____
(Month/Year)

in _____
(City) (State/Country)

_____
(Sign your name here)

_____
(Type or print your name here)

_____
(Capacity of person(s) signing,
e.g., Beneficial Purchaser or Acquirer,
Executor or Administrator)

**ACCURATE CLAIMS PROCESSING TAKES A SIGNIFICANT AMOUNT OF TIME.
THANK YOU FOR YOUR PATIENCE.**

Reminder Checklist:

1. Please sign the above release and declaration.
2. Remember to attach supporting documentation, if available.
3. Do not send original stock certificates.
4. Keep a copy of your claim form for your records.
5. If you desire an acknowledgment of receipt of your claim form, please send it Certified Mail, Return Receipt Requested.
6. If you move, please send us your new address.

Exhibit A-3

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF OHIO
WESTERN DIVISION

In re CHEMED CORP. SECURITIES LITIGATION	No. 1:12-cv-00028-MRB

SUMMARY NOTICE OF PENDENCY OF CLASS ACTION, PROPOSED SETTLEMENT AND SETTLEMENT HEARING

TO: **ALL PERSONS OR ENTITIES WHO PURCHASED CHEMED CORPORATION ("CHEMED") CAPITAL STOCK DURING THE PERIOD FROM FEBRUARY 15, 2010 THROUGH MAY 2, 2013, INCLUSIVE, AND WHO WERE DAMAGED THEREBY.**

YOU ARE HEREBY NOTIFIED, pursuant to Rules 23 of the Federal Rules of Civil Procedure and an Order of the Court, that the above-captioned action has been certified as a class action for settlement purposes only and that a settlement for $6 million has been proposed by the parties. A hearing will be held before the Honorable Michael R. Barrett in the United States District Court for the Southern District of Ohio, Western Division, at __:____ __.m., on _____, 2014, to, among other things: determine whether the proposed Settlement should be approved by the Court as fair, reasonable, and adequate; determine whether, thereafter, this Action should be dismissed with prejudice as to the Defendants and as set forth in the Stipulation and Agreement of Settlement, dated as of February 6, 2014; determine whether the proposed Plan of Allocation for distribution of the settlement proceeds should be approved as fair and reasonable; and consider the application of Co-Lead Counsel for an award of attorneys' fees and payment

of litigation expenses. The Court may change the date of the hearing without providing another notice.

IF YOU ARE A MEMBER OF THE SETTLEMENT CLASS DESCRIBED ABOVE, YOUR RIGHTS WILL BE AFFECTED AND YOU MAY BE ENTITLED TO SHARE IN THE NET SETTLEMENT FUND. If you have not yet received the full printed Notice of Pendency of Class Action and Proposed Settlement, Motion for Attorneys' Fees and Settlement Hearing and a Proof of Claim form, you may obtain copies of these documents by contacting the Claims Administrator:

In re Chemed Corporation Securities Litigation
Claims Administrator
c/o Gilardi & Co. LLC
P.O. Box 990
Corte Madera, CA 94976-0990
www.chemedsecuritiessettlement.com

Inquiries, other than requests for the forms of Notice and Proof of Claim may be made to Co-Lead Counsel:

Evan J. Kaufman
Robbins Geller Rudman & Dowd LLP
58 South Service Road, Suite 200
Melville, NY 11747
(800) 449-4900

Jonathan Gardner
Labaton Sucharow LLP
140 Broadway, 34th Floor
New York, NY 10005
(888) 219-6877

To participate in the Settlement, you must submit a Proof of Claim to the Claims Administrator **no later than _____, 2014**. If you are a Settlement Class Member and do not exclude yourself from the Settlement Class, you will be bound by the Order and Final Judgment of the Court. To exclude yourself from the Settlement Class, you must submit a written, signed request for exclusion so that it is **received by the Claims Administrator no later than _____, 2014**. Any objections to the Settlement must be filed with the Court and sent to counsel **no later than**

_____, 2014. If you are a Settlement Class Member and do not submit a proper Proof of Claim, you will not share in the Settlement but you nevertheless will be bound by the Judgment of the Court.

Further information may be obtained by contacting the Claims Administrator. PLEASE DO NOT CONTACT THE COURT OR THE CLERK'S OFFICE REGARDING THIS NOTICE.

DATED: _____

BY ORDER OF THE COURT
UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF OHIO

Exhibit A-4

UNITED STATES DISTRICT COURT

SOUTHERN DISTRICT OF OHIO

WESTERN DIVISION

In re CHEMED CORP. SECURITIES LITIGATION	)	No. 1:12-cv-00028-MRB
	)	CLASS ACTION
This Document Relates To:	)	Judge Michael R. Barrett
ALL ACTIONS.	)	

[PROPOSED] SECOND AMENDED COMPLAINT

Lead Plaintiffs Electrical Workers Pension Fund, Local 103, I.B.E.W. and Greater Pennsylvania Carpenters Pension Fund ("Lead Plaintiffs" or "Plaintiffs"), by their undersigned attorneys, hereby bring this Second Consolidated Amended Complaint ("Complaint") against Chemed Corporation ("Chemed" or the "Company"), Kevin McNamara, David Williams and Timothy O'Toole (collectively, "Defendants") and allege the following upon knowledge as to their own acts, and upon the investigation conducted by Plaintiffs' counsel as detailed below.

I. NATURE OF THE ACTION

1. This is a federal securities class action brought on behalf of purchasers of the common stock of Chemed between February 15, 2010 and May 2, 2013, inclusive (the "Class Period"), seeking to pursue remedies under the Securities Exchange Act of 1934 (the "Exchange Act").

2. Defendant Chemed operates in two business segments: VITAS Innovative Hospice Care ("VITAS"), a national hospice care provider; and Roto-Rooter, a residential and commercial plumbing and drain cleaner. This action concerns the VITAS hospice segment of Chemed's business. During the Class Period, VITAS accounted for more than 70% of the Company's revenue, with over 90% of VITAS' revenue consisting of payments from Medicare and Medicaid programs. Chemed's ability to grow as a Company, therefore, was closely tied to VITAS' ability to increase reimbursements from federal Medicare and Medicaid programs.

3. Prior to the Class Period, VITAS was moving in the wrong direction. Growth in hospice care admissions was slowing, and with it, growth in revenue and earnings declined as well. Following four consecutive quarters of declining admissions growth, Defendants embarked on a fraudulent scheme to reverse this trend. To the investing public, Defendants announced that VITAS planned to increase admissions (and, thereby, increase payments from Medicare and Medicaid) by improving employee training, by doing a better job processing new admissions, by increasing its

marketing efforts and by pursuing non-traditional referral sources. Unbeknownst to investors, however, the plan, which unmistakably came from the top echelon of Chemed's management team, promoted the clear-cut circumvention of Medicare and Medicaid rules and regulations to increase revenue coming from these government programs.

4. In furtherance of its maneuver to increase admissions and federal government reimbursements, VITAS engaged in a wide-spread fraud, each element of which led to the submission of improper and ineligible claims to Medicare and Medicaid. The first step in the scheme to enroll hospice care patients who did not qualify for Medicare or Medicaid benefits involved the inadequate training of VITAS' employees, who were never properly instructed in vetting which patients actually qualified for hospice care under Medicare's eligibility criteria. This lack of training led to the second step in the scheme: the admission of patients into VITAS' hospice care who were not terminally ill - a requirement for hospice care reimbursement under Medicare, and to the recertification of patients for continued hospice care even when those patients no longer met Medicare's eligibility criteria. To further increase its hospice care census, VITAS automatically enrolled new hospice patients discharged from hospitals in continuous home care, the level of care with the highest rate of compensation, without regard to the actual medical needs of the patient.

5. Throughout the Class Period, VITAS physicians and admitting nurses were pressured by general managers and marketing personnel to admit and recertify as many patients as possible, without regard to the eligibility of those patients for Medicare's hospice reimbursement. By manipulating the manner in which patients' admission forms were completed, these practices allowed VITAS to improperly receive payments from Medicare and Medicaid for services rendered to ineligible patients and for a level of care well beyond that which was permissible.

6. Defendants publicly touted VITAS' improved financial performance without disclosing the manipulation of Medicare and Medicaid rules and regulations employed to achieve the enhanced results.

7. Defendants' materially false and misleading statements alleged herein caused the artificial inflation of Chemed's stock price during the Class Period. Defendants took advantage of the artificially inflated Chemed stock price in two ways: 1) they sold over $14.4 million of Chemed shares that they knew carried an artificially inflated value at the time they sold those shares during the Class Period; and 2) they reaped additional rewards from the Company's Executive Long Term Incentive Plan, designed to reward executives for improving the Company's financial performance, but used here to improperly reward Defendants for their misconduct.

8. By mid-2011, as government reimbursements to hospice providers and particularly *for-profit* hospice providers, like VITAS, increased at alarming rates, concerned federal officials put hospice providers in their cross-hairs in an effort to determine why hospice care disbursements had increased so significantly. On July 18, 2011, the Office of Inspector General ("OIG"), the government entity involved in investigating hospice providers for compliance with Medicare rules and regulations, published a report entitled, "Medicare Hospices That Focus on Nursing Facility Residents," which outlined concerns about inappropriate enrollment and compensation for hospice services provided to nursing facility residents. Specific hospices were not identified in this report.

9. Defendants, however, continued to tout Chemed's purported compliance with Medicare rules and regulations in their public statements and affirmatively denied their involvement in the types of activities discussed in the OIG report. During an investor conference held on July 27, 2011, Defendant O'Toole responded to questions about the OIG report, by saying, "***[w]e don't have that issue at all. We are very comfortable with where we sit.***"[1]

[1] All emphasis is added unless otherwise noted.

10. Only four months later, on November 16, 2011, *Bloomberg News* published an article entitled "Whistleblower Accuses Chemed Unit of Medicare HMO Conspiracy." The article disclosed that a former VITAS general manager charged VITAS with defrauding the federal government by conspiring with health insurers to enroll patients into hospice care even when those patients were not dying, making VITAS' reimbursements from Medicare improper and in violation of Medicare's rules and regulations. Shockingly, the *qui tam* lawsuit detailed how several of VITAS' highest level managers were complicit in this corporate-wide effort to circumvent Medicare rules and regulations. The article further reported that a U.S. Department of Justice ("DOJ") investigation had commenced to determine whether VITAS entered into a widespread, "extensive scheme" to defraud Medicare and Medicaid of "hundreds of millions of dollars" by falsifying records *and hospice certifications.* The article also stated that the Texas Attorney General's office was investigating VITAS and had filed a notice with the court to obtain information from the Company.

11. During the Class Period, Chemed's stock traded as high as $80.68 per share on February 20, 2013.

12. The news about VITAS on November 16, 2011 sent Chemed's stock plummeting. On November 16, 2011, after news became public of the breadth of the DOJ investigation into VITAS and the scope of the whistleblower action, Chemed's stock fell $6.87 per share, or 11%, to close at $50.65 per share on extremely heavy trading volume.

13. While the November 16, 2011 *Bloomberg News* article informed investors that Chemed's improved financial condition was a result of their improper scheme to defraud the government, the scope and breadth of Defendants' fraud was made abundantly clearer upon the subsequent disclosure of additional federal and state investigations, the unsealing of newly filed *qui*

tam lawsuits and ultimately, the filing of a federal False Claims Act ("FCA") lawsuit by the DOJ alleging that VITAS and Chemed engaged in widespread Medicare fraud.

14. On August 2, 2012, Chemed announced that VITAS had received an administrative subpoena from the OIG in June 2012 in connection with an investigation of improper claims submitted to Medicare and Medicaid, requesting documents related to VITAS' hospice program in Southern California.

15. On November 2, 2012, Chemed disclosed that VITAS had received a subpoena from the Florida Attorney General in July 2012 seeking various categories of documents related to VITAS' improper provision of hospice care in Florida. Chemed also disclosed certain details contained in two *qui tam* complaints, now unsealed, both alleging that Chemed violated the FCA by submitting fraudulent claims to Medicare for patients inappropriately admitted for hospice care. Chemed further stated that VITAS received another administrative subpoena from the OIG in September 2012 seeking production of medical records for patients from 10 states who received continuous care at VITAS' facilities.

16. After the stock market closed on May 2, 2013, it was announced that the DOJ filed a complaint against Chemed and VITAS in the Western District of Missouri captioned *United States v. Vitas Hospice Services LLC, et al*. (W.D. Mo.) (the "DOJ Complaint").[2] The DOJ Complaint alleges that starting in at least 2004 and "even to this day" VITAS and Chemed were knowingly billing Medicare for patients who did not satisfy the eligibility requirements for hospice care. In response to this news, Chemed's stock price plummeted $13.79 per share, or 16.86%, to close at $68.00 per share on May 3, 2013 on extremely heavy trading volume.

[2] The DOJ Complaint is attached hereto as Exhibit A.

II. JURISDICTION AND VENUE

17. The claims asserted herein arise under and pursuant to Sections 10(b) and 20(a) of the Exchange Act [15 U.S.C. §§78j(b) and 78t(a)] and Rule 10b-5 promulgated thereunder by the Securities and Exchange Commission ("SEC") [17 C.F.R. §240.10b-5].

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

19. Venue is proper in this District pursuant to Section 27 of the Exchange Act, and 28 U.S.C. §1391(b), as and many of the acts and practices complained of herein occurred in substantial part in this District.

20. In connection with the acts alleged in this complaint, Defendants, directly or indirectly, used the means and instrumentalities of interstate commerce, including, but not limited to, the mails, interstate telephone communications and the facilities of the national securities markets.

III. PARTIES

21. Lead Plaintiffs Electrical Workers Pension Fund, Local 103, I.B.E.W. and Greater Pennsylvania Carpenters Pension Fund, as set forth in their certifications previously filed with the Court and incorporated by reference herein, purchased the common stock of Chemed at artificially inflated prices during the Class Period and have been damaged thereby.

22. Defendant Chemed provides hospice care through its subsidiary VITAS, and plumbing repair and drain cleaning services through its subsidiary Roto-Rooter. The Company maintains its principal executive offices in this District.

(a) Defendant Kevin McNamara ("McNamara") was President and Chief Executive Officer ("CEO") of Chemed during the Class Period and has held these positions since August 1994 and May 2001, respectively. Previously, he served as an Executive Vice President, Secretary and General Counsel of the Company, since November 1993, August 1986 and August

1986, respectively. Before that, he held the position of Vice President of the Company, from August 1986 to May 1992.

(b) Defendant David Williams ("Williams") was Executive Vice President ("EVP") and Chief Financial Officer ("CFO") of Chemed during the Class Period and has held these positions since August 10, 2007 and March 5, 2004, respectively.

(c) Defendant Timothy O'Toole ("O'Toole") was CEO of the VITAS segment of Chemed and an EVP of Chemed during the Class Period and has held this position since February 24, 2004. During the Class Period, O'Toole was also an EVP of Chemed and has held this position since May 1992. Previously, from May 1992 to February 24, 2004, he also served as Chemed's Treasurer.

(d) Defendants McNamara, Williams, and O'Toole are collectively referred to herein as the "Individual Defendants." Chemed and the Individual Defendants are collectively referred to herein as "Defendants."

23. Because of the Individual Defendants' positions with the Company, they had access to the adverse undisclosed information about the Company's business, operations, operational trends, financial statements, markets and present and future business prospects via internal corporate documents, conversations and connections with other corporate officers and employees, attendance at management and Board of Directors' meetings and committees thereof and via reports and other information provided to them in connection therewith.

24. Each of the above officers of Chemed, by virtue of their high-level positions with the Company, directly participated in the management of the Company, especially VITAS, was directly involved in the day-to-day operations of the Company at the highest levels and was privy to confidential proprietary information concerning the Company and its business, operations, growth, financial statements, and financial condition, as alleged herein. Said Defendants had the ultimate

authority over and were involved in drafting, producing, reviewing and/or disseminating the false and misleading statements and information alleged herein, were aware, or recklessly disregarded, that the false and misleading statements were being issued regarding the Company, and approved or ratified these statements, in violation of the federal securities laws.

25. As officers and controlling persons of a publicly-held company whose common stock was, and is, registered with the SEC pursuant to the Exchange Act, and was, and is, traded on the New York Stock Exchange ("NYSE"), and governed by the provisions of the federal securities laws, the Individual Defendants each had a duty to promptly disseminate accurate and truthful information with respect to the Company's financial condition and performance, growth, operations, financial statements, business, markets, management, earnings and present and future business prospects, and to correct any previously-issued statements that had become materially misleading or untrue, so that the market price of the Company's publicly-traded common stock would be based upon truthful and accurate information. The Individual Defendants' misrepresentations and omissions during the Class Period violated these specific requirements and obligations.

26. The Individual Defendants had ultimate authority over, and participated in the drafting, preparation, and/or approval of the various public and shareholder and investor reports and other communications complained of herein and were aware of, or recklessly disregarded, the misstatements contained therein and omissions therefrom, and were aware of their materially false and misleading nature. Because of their executive and managerial positions with Chemed, each of the Individual Defendants had access to the adverse undisclosed information about Chemed's financial condition and performance as particularized herein and knew (or recklessly disregarded) that these adverse facts rendered the positive representations made by or about Chemed and its business issued or adopted by the Company materially false and misleading.

27. The Individual Defendants, because of their positions of control and authority as officers of the Company, were able to and did control the content of the various SEC filings, press releases and other public statements pertaining to the Company during the Class Period. Each Individual Defendant was provided with copies of the documents alleged herein to be misleading prior to or shortly after their issuance and/or had the ability and/or opportunity to prevent their issuance or cause them to be corrected. Accordingly, each of the Individual Defendants is responsible for the accuracy of the public reports and releases detailed herein and is therefore primarily liable for the representations contained therein.

28. Each of the Defendants is liable as a participant in a fraudulent scheme and course of business that operated as a fraud or deceit on purchasers of Chemed common stock by disseminating materially false and misleading statements and/or concealing material adverse facts. The scheme: (i) deceived the investing public regarding VITAS' business, operations, management and the intrinsic value of Chemed common stock; (ii) enabled the Individual Defendants and other Chemed insiders to sell almost 100,000 shares of their personally-held Chemed common stock, generating proceeds of more than $14.4 million; (iii) provided each of the Individual Defendants with additional bonus compensation pursuant to the Company's Long Term Incentive Plan; and (iv) caused Plaintiffs and other members of the Class to purchase Chemed common stock at artificially inflated prices.

IV. CLASS ACTION ALLEGATIONS

29. Plaintiffs bring this action as a class action pursuant to Federal Rule of Civil Procedure 23(a) and (b)(3) on behalf of a class consisting of all those who purchased the common stock of Chemed during the Class Period and who were damaged thereby (the "Class"). Excluded from the Class are Defendants, the officers and directors of the Company, at all relevant times,

members of their immediate families and their legal representatives, heirs, successors or assigns and any entity in which Defendants have or had a controlling interest.

30. The members of the Class are so numerous that joinder of all members is impracticable. Throughout the Class Period, Chemed common shares were actively traded on the NYSE under the ticker symbol "CHE." According to Chemed's Form 10-Q dated November 4, 2011, as of September 30, 2011, 19,881,497 shares of Chemed stock were outstanding. While the exact number of Class members is unknown to Plaintiffs at this time and can only be ascertained through appropriate discovery, Plaintiffs believe that there are hundreds or thousands of members in the proposed Class. Record owners and other members of the Class may be identified from records maintained by Chemed or its transfer agent and may be notified of the pendency of this action by mail, using the form of notice similar to that customarily used in securities class actions.

31. Plaintiffs' claims are typical of the claims of the members of the Class as all members of the Class are similarly affected by Defendants' wrongful conduct in violation of federal law that is complained of herein.

32. Plaintiffs will fairly and adequately protect the interests of the members of the Class and have retained counsel competent and experienced in class and securities litigation.

33. Common questions of law and fact exist as to all members of the Class and predominate over any questions solely affecting individual members of the Class. Among the questions of law and fact common to the Class are:

(a) whether the federal securities laws were violated by Defendants' acts as alleged herein;

(b) whether statements made by Defendants to the investing public during the Class Period misrepresented or omitted material facts about the business, operations and management of Chemed;

(c) whether the Individual Defendants acted with scienter; and

(d) to what extent the members of the Class have sustained damages and the proper measure of damages.

34. A class action is superior to all other available methods for the fair and efficient adjudication of this controversy since joinder of all members is impracticable. Furthermore, as the damages suffered by individual Class members may be relatively small, the expense and burden of individual litigation make it impossible for members of the Class to individually redress the wrongs done to them. There will be no difficulty in the management of this action as a class action.

V. BASIS OF ALLEGATIONS

35. The allegations herein are based on Plaintiffs' personal knowledge as to their own acts and on information and belief as to all other matters, such information and belief having been informed by the investigation conducted by, and under the supervision of, their counsel, which included reviewing and analyzing publicly available information relating to the relevant time period obtained from numerous public and proprietary sources (such as LexisNexis, Dow Jones and Bloomberg, Inc.), SEC filings by Chemed, regulatory filings and reports, securities analysts' reports and research data, investor conference transcripts, Company advisories, press releases and other public statements issued by the Company, media reports, news articles and the DOJ Complaint. Plaintiffs believe that substantial additional evidentiary support will exist for the allegations set forth herein after a reasonable opportunity for discovery.

36. Moreover, the allegations made herein are supported by the first-hand knowledge of 20 confidential witnesses ("CWs") – all former employees who describe their experiences at VITAS during their tenure (some of whom have provided information in confidence, these CWs will be identified herein by number (CW1, CW2, *etc*.) and will be described in the masculine in all cases in

order to protect their identities). As detailed below, the CWs each served in positions at VITAS that provided them with access to information as alleged herein.

(a) CW1 was employed as Director of Market Development for VITAS' Hartford, Connecticut region from September 2008 to September 2011. In this capacity, CW1 supervised a team of sales representatives responsible for communicating with long term care facilities, nursing homes and physicians in the Hartford area to market VITAS' hospice services. CW1 reported directly to Michelle Hanlon, the general manager of VITAS' operations in Hartford, Connecticut.

(b) CW2 was the former Senior Director of Compliance at VITAS from July 2007 through May 2010. As Senior Director, CW2 was responsible for assisting and putting together VITAS' financial statements and implementing VITAS's internal controls. CW2 reported to former Controller, Lawrence Press, and Chief Accounting Officer, Burt Tracey.

(c) CW3 was a former patient care administrator at VITAS' operations for the Columbus, Ohio program from January 2011 through October 2011, when he resigned. CW is a registered nurse. As a patient administrator, CW3 was responsible for supervising patient care teams to provide medical, social and emotional support to patients and their families. CW3 reported to Steve Wishart the general manager, who reported to Joanne Mack.

(d) CW4 served as VITAS' Director of Market Development at the New Jersey North office from March 2009 through April 2011. In CW4's capacity as Director of Market Development, CW4 headed up a team of marketers who sought leads and referrals for the Company's hospice care programs. CW4 reported to VITAS' general manager of operations in the New Jersey region.

(e) CW5 was a former admissions nurse at the Sacramento, California location of VITAS from February 2008 through October 2010. As an admissions nurse, CW5 was responsible

for conducting patient assessments and recommending whether a particular patient qualified for hospice services. CW5 reported to the nursing supervisor of admissions.

(f) CW6 was employed at VITAS' Dublin, Ohio facility from November 2010 through October 2011. CW6 first served as a case manager, but became an admitting nurse in July 2011. As an admitting nurse, CW6 was responsible for interviewing and examining patients to determine if they qualified for hospice services. CW6 reported to the patient care administrator.

(g) CW7 was employed in VITAS' Coachella Valley, California location as a registered nurse from the spring of 2009 through spring of 2010. Coachella Valley was a satellite office for VITAS' San Bernardino, California location. As a registered nurse at VITAS, CW7 admitted patients and provided patient care. CW7 reported to former team manager, Harris Jamison, who, in turn, reported to patient care administrator, Anne Beamesderfer.

(h) CW8 was employed as a marketer for VITAS' Pittsburgh, Pennsylvania branch from December 2007 through October 2010. As a marketer, CW8 was responsible for obtaining referrals of patients for hospice admissions. CW8 reported to Mark Cadence, the general manager of the Pittsburgh branch.

(i) CW9 was employed at VITAS' Encino, California location as an admissions nurse from August 2009 through approximately November 2009. From November 2009 through February 2011, CW9 worked as a case manager at the VITAS Camarillo, California location. As an admission nurse at Encino, CW9 was responsible for assessing patients for appropriateness for hospice care. As a case manager at Camarillo, CW9 was responsible for overseeing patient care, reporting changes in the patient's condition to the medical director, reporting the patient's status to the medical director, and monitoring the patient. At Encino, CW9 reported to the admissions supervisor, Jack Guinn, and Guinn reported to general manager Susie Fishenfeld. At Camarillo, CW9 reported to Gail Hart who reported directly to patient care administrator Anne Beamsdorfer.

(j) CW10 was employed as an admission nurse from September 2009 through August 2011, at VITAS' Walnut Creek, California location. As an admitting nurse, CW10 was responsible for interviewing and examining patients to see if they qualified for hospice care. In this capacity, CW10 reported directly to admissions manager Jill Heifetz, who reported to general manager Bruce Davis.

(k) CW11 was employed as a hospital sales representative by VITAS' San Bernardino, California location from November 2008 to March 2011. As a sales representative, CW11 marketed VITAS' services to hospitals and doctors' offices and, at times, directly to the patients and/or their families. CW11 reported to Mary Beth Wadding, the Director of Marketing. Wadding reported to general manager Steve Girod and regional vice president of marketing Mary Ann Davidson.

(l) CW12 was employed as an admissions coordinator at the Lombard, Illinois call center from 2008 until August 2011. CW12 was responsible for dispatching admission nurses to evaluate patients and evaluated the patients' charts that were entered into the computer system that CW12 had access to. Once a referral had been entered into the system, CW12 was responsible for calling the patient's family on a consistent basis to ask if they were ready to transfer the patient to hospice care. CW12 reported to director of customer service Deborah Lipinski who reported to call center general manager Carol DeGrazia. DeGrazia reported to telecare services general manager Julie Dayiantis.

(m) CW13 was a certified nurse practitioner at the palliative care program in VITAS' Pittsburgh, Pennsylvania location from May 2010 until June 2011. CW13 reported to the general manager of the palliative care program, Jim Joyce, who reported to both the executive director of palliative care, Dawn DaSilva, and the GM of the VITAS hospice program in Pittsburgh, PA, Mark Katich, who in turn reported to regional vice president Rosemary Baughn.

(n) CW14 was a marketing representative at VITAS' Boynton Beach, Florida location from January 2009 until May 2011. CW14 was responsible for marketing to nursing homes and to doctors who worked at nursing homes. CW14 reported to the director of marketing development, Nancy Boulter, who reported to a regional director of marketing, Jane Merritt, and the program general manager, Susan Acocella, who reported to Senior Vice President of Market Development and Sales, Donald Gaddy.

(o) CW15 was a hospice representative at VITAS' Fort Lauderdale, Florida location from December 2009 to August 2010. CW15 was responsible for marketing to hospitals, independent living facilities, nursing facilities, assisted living facilities and doctors' offices. CW15 reported directly to the director of business development, Richard Deal, who reported to the general manager of the Fort Lauderdale location, Mary Zalaznik, who reported to the Senior Vice President of Market Development and Sales, Donald Gaddy.

(p) CW16 was a business development and admissions representative employed in VITAS' Boynton Beach, Florida location from before the Class Period through the summer of 2012. CW16 was responsible for sales and marketing of hospice services in the Northern Palm Beaches and for reviewing the charts of medical and pharmaceutical criteria for hospice admissions. CW16 reported to director of market development, Nancy Boulter, who reported to regional director of market development Jane Merritt.

(q) CW17 was a staff nurse for continuous care from November 2005 to January 2011. He first worked at the Chicagoland NW location (Lombard, Illinois) as a Staff Nurse on the Continuous Care team from November 2005 to May 2009, and then as a Telecare Nurse from May 2009 to May 2010 at the same location. CW17 finished his tenure at VITAS as a Staff Nurse on the Continuous Care Team of the Chicagoland Central location (Chicago, Illinois) from May 2010 to January 2011. CW17's responsibilities as a Staff Nurse included providing continuous care and

monitoring and documenting the status of terminal patients. As a Telecare Nurse, his responsibilities included ordering home medical equipment, verifying medication orders, and receiving calls from vendors, nurses and other employees for the purposes of assessing the patients' health. During his employment as both Staff Nurse and Telecare Nurse at the Chicagoland NW location, CW17 reported to Continuous Care Supervisor, Joann Gawczynski. CW17 reported to Continuous Care Supervisor Gwendolyn Crowder at Chicagoland Central during CW17's tenure as a Staff Nurse on a continuous care team.

(r) CW18 was a medical social worker and community liaison at VITAS' Torrance, California location from 2009 until March 2011. As a medical social worker, CW18 met with patients, collected patient information and coordinated follow-up assessments. As a community liaison, CW18 provided hospice education in assisted living and skilled nursing facilities, as well as physicians' offices. CW18 reported to Donna Scott, assistant clinical director who reported to general manager Marie Hagerty who reported to Joanne Mack, regional Vice President of Hospice Operations.

(s) CW19 was an admission manager of VITAS' three Connecticut locations from approximately 2006 to October 2010. CW19 was an admissions manager at VITAS' Middlebury, Connecticut location the entire time, and served in that capacity at VITAS' Hartford and Fairfield, Connecticut locations for approximately one year, from the middle of 2008 to the middle of 2009. As an admissions manager, CW19 evaluated every potential new patient for their appropriateness for hospice. CW19 also supervised admitting nurses. CW19 reported to Patient Care Administrator ("PCA") Nancy Petrowski and then PCA Beth Keitzer. Both PCAs reported to General Manager Theresa Bachuber ("Bachuber").

(t) CW20 was a registered nurse at the VITAS inpatient unit at St. Mary's hospital in Waterbury, Connecticut from March 2011 to June 2012. CW20 was responsible for

conducting a "head-to-toe" assessment of the patient for hospice eligibility, making sure that documentation met VITAS standards, providing psycho-social support and spiritual support for the patient, and medical and social needs of the patient and family. CW20 reported to the patient care manager Cindy Fitzmaurice who reported to the Middlebury patient care manager Beth Keitzer.

VI. SUBSTANTIVE ALLEGATIONS

A. The Company and Its Core Business – VITAS

37. Defendant Chemed, through its subsidiaries, provides hospice care, plumbing and drain repair and cleaning services in the United States. The Company operates in two segments, VITAS and Roto-Rooter. The VITAS segment offers hospice care services, including routine home care, general inpatient care, continuous care, and respite care. It also offers spiritual and emotional counseling to patients and their families through its team of doctors, nurses, home health aides, social workers, clergy, and volunteers. The Roto-Rooter segment provides plumbing repair and cleaning services, including sewer, drain, and pipe cleaning, as well as plumbing repair to residential and commercial customers through its network of Company-owned branches, independent contractors, and franchisees. The Company was founded in 1970 and is headquartered in Cincinnati, Ohio.

38. This action concerns the VITAS hospice segment of Chemed's business, which, during the Class Period, accounted for more than 70% of the Company's revenue and a similar percentage of the Company's after-tax profit. In the larger VITAS segment, more than 90% of the segment's revenue was generated from Medicare and Medicaid reimbursements, which were made on a "per diem" basis.

B. The Medicare Hospice Benefit

39. The Medicare Hospice Benefit ("MHB") covers palliative and support services for terminally ill beneficiaries. To be eligible for hospice care, a physician must certify that the patient is "terminally ill." 42 U.S.C. §1395f(a)(7). An individual is considered terminally ill if he or she

has "a medical prognosis that the individual's life expectancy is 6 months or less." 42 U.S.C. §1395x(dd)(3).

40. The services covered under MHB include, among others, nursing care; physical, occupational or speech therapy; medical social services; home health aide and homemaker services; physician services; counseling; short-term inpatient care; drugs and biologicals for symptom control; home medical equipment; bereavement services; and other services for palliation of the terminal condition. 42 U.S.C. §1395x(dd)(1).

41. Beneficiaries who elect the MHB agree to forgo Medicare coverage for treatment of their terminal illness. Once admitted to a hospice program, a written plan of care is established and maintained by an attending physician, medical director or another hospice physician. 42 U.S.C. §1395f(a)(7)(B).

C. Medicare Eligibility for Hospice Services

42. Once a beneficiary elects hospice services, a hospice physician and the patient's attending physician, must certify that the beneficiary has a life expectancy of six months or less if the terminal illness runs its normal course. 42 U.S.C. §1395f(a)(7)(A).

43. If a patient is admitted into hospice care and survives for 90 days, the patient is reassessed. If the terminally ill beneficiary continues to have a life expectancy of six months or less, the patient can be recertified for another 90 days. *Id.* Following the second 90 day period, as long as the patient remains eligible for MHB, the patient can be recertified for an unlimited number of 60 day benefit periods. 42 U.S.C. §1395d(a)(4). For recertification, only the hospice physician must certify that the beneficiary's life expectancy is six months or less. 42 U.S.C. §1395f(a)(7)(A).

44. All certifications and recertifications must include a brief physician narrative explaining the clinical basis for the patient's prognosis. 42 U.S.C. §418.22(b)(3).

45. In addition to the requirements covering the eligibility of Medicare beneficiaries for hospice care benefits, there are also federal regulations governing the hospice program itself. To that end, a hospice program must satisfy certain Conditions of Participation ("COP") to be certified and to receive Medicare payment for the services it provides.

46. One such COP requires the hospice to obtain the "informed consent" of the hospice patient, or the patient's legal representative, specifying the type of care services that will be provided. Admitting a hospice patient, even for a short time, without the patient's informed consent violates the COP.

47. In addition, to satisfy the COP requirement, a written plan of care for the patient must be established and developed prior to the administration of any care by an interdisciplinary team, which includes the patient's attending physician and the medical director at the hospice. The plan must assess the patient's needs, identify services to be provided to meet those needs, and must be reviewed and updated at specified intervals.

48. The COP requirements also mandate that hospice care employees receive ongoing training in the provision of hospice care services.

D. Medicare Payment for Hospice

49. Medicare pays hospice providers a daily rate for each day a beneficiary is enrolled in hospice. Accordingly, the longer a patient is enrolled in hospice, the more revenue the hospice provider generates.

50. Payments are made according to a fee schedule that has base payment amounts for four categories of care: (i) routine home care; (ii) continuous home care; (iii) inpatient respite care; and (iv) general inpatient care. In fiscal year 2010, the routine home care rate was $143 per day. The routine home care rate is paid for each day that a patient is enrolled in a hospice program and does not receive any of the other types of hospice care. For continuous home care (home care

provided during periods of patient crisis), the hospice is paid an hourly rate ($34.75 per hour in 2010) for care delivered during periods of crisis if care is provided in the home for 8 or more hours within a 24-hour period. The rate for inpatient respite care – short period inpatient care to provide respite for a primary caregiver – was $148 per day in 2010, and $636 per day for general inpatient care to treat symptoms that cannot be managed in another setting.

E. Avoiding Medicare Cap Penalty Created Additional Need to Increase Admissions

51. The "Medicare cap" limits the total aggregate payment an individual hospice can receive in a year and is calculated by multiplying the number of beneficiaries who have elected hospice care during an accounting year by a per beneficiary "cap amount." It was crucial for the Company not to exceed the Medicare cap limit because the Company would then have to record a liability and reimburse Medicare for the difference at the end of that year.

52. Prior to the Class Period, VITAS suffered a significant decline in hospice admissions. Indeed, between the third quarter of 2008 to the second quarter of 2009, VITAS experienced four consecutive quarters of negative hospice admissions growth. The decline was due, in part, to competition from other hospice providers and weak industry trends.

53. Negative admissions growth is reflected in the Company's financial statements in the form of slower revenue growth and lower earnings. Negative admissions growth may cause a hospice provider to exceed the Medicare cap limit. To avoid these outcomes, Defendants mandated material changes to VITAS' business model to increase hospice admissions. Unbeknownst to investors, however, these changes involved the improper admission and recertification of hospice patients and the institution of billing practices designed to circumvent Medicare's rules and regulations.

F. Hospice Providers Become Subject to Heightened Scrutiny

54. As Medicare spending on hospice rose 70% from 2005 through 2009, hospice providers started to face increased scrutiny from regulators.

55. In June 2008 and March 2009, the Medicare Payment Advisory Commission ("MedPAC") analyzed the hospice benefit and found that Medicare's hospice payment system contains incentives that make very long stays in hospice more profitable for providers than short stays, which may lead to inappropriate utilization of the benefit among some hospices. MedPAC also found that the Center for Medicare and Medicaid Services ("CMS") lacks adequate administrative and other controls to check the incentives for long stays in hospice or ensure providers' compliance with the benefit's eligibility criteria. In particular, MedPAC found: (i) an increase in the number of hospices, driven almost entirely by growth in for-profit providers; (ii) an increase in average length of stay due to increased lengths of stay among patients with the longest stays; (iii) a positive correlation between hospice profit margins and average length of stay; (iv) reports that some hospices admit patients who do not meet the Medicare hospice eligibility criteria of a life expectancy of six months or less; and (v) efforts by hospices to enroll nursing home residents and reports of questionable relationships between some nursing facilities and hospices.

56. In addition, the OIG became increasingly involved in investigating hospice care providers and their compliance with Medicare and Medicaid regulations. On or about July 18, 2011, the OIG published a report titled "Medicare Hospices That Focus on Nursing Facility Residents," detailing concerns with the provision of hospice care for nursing facility residents, including inappropriate enrollment and claims for compensation submitted to Medicare. The OIG found that these hospices seek out patients with conditions that typically require longer stays and less complex care. The report noted the OIG's intent to look at marketing practices of these hospices and their

relationships with nursing facilities. Neither Chemed nor VITAS were specifically mentioned in this report.

G. The VITAS Hospice Program

57. Headquartered in Miami, Florida, VITAS is one of the nation's largest hospice providers. During the Class Period, it served patients through Medicare-certified hospice programs in 16 states: California, Connecticut, Delaware, District of Columbia, Florida, Georgia, Illinois, Kansas, Michigan, Missouri, New Jersey, Ohio, Pennsylvania, Texas, Virginia and Wisconsin. VITAS' largest markets were Florida and California.

58. VITAS provides its hospice services primarily in the patients' homes, but also provides services in inpatient hospice units, hospitals, nursing homes and assisted living communities/residential care facilities for the elderly. VITAS contracts with several health care providers and practitioners, including physicians, hospitals and nursing homes and arranges for these entities to provide services to VITAS patients.

59. Patients are referred to VITAS by physicians, hospitals, long-term care facilities and other institutional health care providers. Some of these referral sources have contracts with VITAS to provide services to VITAS patients.

60. Marketing personnel employed by VITAS are responsible for securing the referral of patients for hospice admissions and receive bonuses based on the number of patients who they refer *and who enroll* for hospice care. Marketers forward a patient's name and information to a VITAS admissions nurse. The admissions nurse examines the patient to determine the patient's eligibility for hospice care under the relevant Medicare and Medicaid rules and regulations. The admitting nurse relates his or her findings to a VITAS physician, who, most often based solely upon the evaluation and determination of an admitting nurse, decides if he should certify that patient as "terminally ill" and, therefore, qualified for hospice care.

61. VITAS keeps track of its potential patient referrals using an internal reporting system called Salesforce. According to a former VITAS marketer, CW8, the sales data and referral reports on Salesforce are monitored daily by VITAS' corporate office. CW15 confirmed that the Salesforce program contained census information, including the amount of time a patient had been on hospice. According to CW15, "[e]veryone had access to Salesforce including corporate."

62. Indeed, during the Class Period, VITAS' corporate officers monitored the most important elements of VITAS' business, including admissions, discharge rate and median length of patient stay. VITAS' former Senior Director of Compliance, CW2, reported that a "census" specifically monitoring hospice admissions was generated at the corporate level and updated daily. The census was created for upper management, including managers and directors, and allowed them to track the performance of VITAS' business. According to CW2, VITAS directors were always looking at admissions numbers and had access to the census via computer log-in. CW2 recalled that the census also included "budget" numbers that VITAS was required to achieve monthly, as well as length of patient stay. CW2 further noted that Defendant O'Toole regularly discussed numbers contained in the census with VITAS' CFO.

63. As the Company admitted in its annual reports for the years ended December 31, 2009 and December 31, 2010, filed with the SEC on Form 10-K, Defendants "actively monitor[ed] each of [their] hospice programs, by provider number, as to their specific admissions, discharge rate and median length of stay data in an attempt to determine whether they are likely to exceed the Medicare cap."

64. Along with VITAS' management, "Chemed management regularly corresponded with Vitas management about the average daily census and growth in admissions, making focused, frequent inquiries if they believed the numbers reported were too low." DOJ Complaint ¶161.

65. As alleged *infra*, Defendants engaged in an extensive, ***company-wide*** scheme to: (i) enroll and keep patients in hospice even though those individuals were not eligible for hospice care; (ii) enroll and keep patients in the more expensive continuous care level of service, including those who were not eligible for this "crisis care"; and (iii) fraudulently obtain payments for these hospice services from the federal government. A material portion of Chemed's revenues, earnings and hospice enrollments in the VITAS segment were inflated during the Class Period due to these and other fraudulent practices.

H. Throughout the Class Period, Defendants Circumvented Medicare Rules and Regulations

66. In an effort to turn around VITAS' streak of negative admissions growth, Defendants engaged in a Company-wide scheme of admitting patients who were not eligible for hospice care and billed Medicare for their services to such patients. Indeed, following a lengthy investigation, the DOJ concluded: "Vitas's corporate culture encouraged its marketing and clinical staff to admit as many patients as possible, regardless of whether they were eligible for hospice." DOJ Complaint ¶164.

67. While Medicare rules and regulations require a physician to certify a patient for admission to hospice care, at VITAS, that certification was wholly dependent upon the evaluation of the only person who met with the patient prior to admission, the admitting nurse. Thus, by exerting pressure on its admitting nurses to ratify the admission of non-terminally ill patients (¶¶73-93, *infra*), VITAS enabled physicians to ultimately certify the admission of ineligible patients.

1. VITAS Fails to Properly Train and Teach Employees the Requirements for Medicare Coverage

68. Given the importance VITAS had to Chemed's overall success and the significance of the revenues received directly from Medicare, VITAS had a duty to obtain a thorough understanding of the Medicare hospice program. Inherent in that duty was their obligation to properly train and inform its employees regarding the requirements for Medicare coverage of hospice services. DOJ Complaint ¶31.

69. As the DOJ observed, VITAS did not properly train its staff on hospice eligibility criteria. A former VITAS medical director stated that he received no training at all from VITAS on Medicare eligibility requirements for hospice. VITAS expected this former medical director to certify patients as eligible for hospice without first determining that the patient had a prognosis of six months or less to live should the patient's illness run its normal course. In contrast, numerous VITAS marketing employees informed the DOJ that VITAS spent a significant amount of resources training its marketing employees on how to "sell hospice" to patients, patients' families, and referral sources for potential hospice patients. DOJ Complaint ¶169.

70. VITAS employed field nurses to provide care to its hospice patients residing in skilled nursing facilities, assisted living facilities, and hospitals, but did not adequately teach the nurses of the eligibility requirements for Medicare eligibility. DOJ Complaint ¶170.

71. VITAS directed these untrained field nurses, as part of their roles and responsibilities, to identify elderly people who were eligible for the Medicare hospice benefit, and to encourage the referral of elderly people to VITAS for end of life care. DOJ Complaint ¶171.

72. The allegations of inadequate and improper training alleged by the DOJ are supported by CW4, who stated that at his VITAS location, there was an inconsistency in admissions due to a lack of training of staff to identify hospice-appropriate patients, which led to the admission of inappropriate patients.

2. VITAS Pressures Admission Nurses to Admit Non-Terminally Ill Patients

73. As detailed by numerous former VITAS employees who worked at the Company during the Class Period, there was immense pressure at VITAS to routinely admit as many patients to hospice as possible, regardless of their eligibility. VITAS put pressure on admission nurses because nurses were typically the ones who evaluated the patient for hospice eligibility. Admission nurses would present their findings to doctors who would rely on the nurses' assessment in making a

determination as to whether to admit a patient to hospice[3]. This is corroborated by several CWs. For example, CW3 explained that when a patient is referred to VITAS, a VITAS admissions nurse conducts a medical examination of the patient. The admissions nurse reports her findings to a VITAS physician. The VITAS physician determines eligibility based on the nurse's assessment and report. CW6 confirmed this process, stating that physicians went along with the nurse's recommendations. CW6 stated that because the nurse was the one who evaluated the patient, the doctors had to trust his or her judgment. CW5 stated that while a doctor would make the referral, the patient could not be admitted unless an admissions nurse approves that they meet the criteria. CW19 corroborated this stating that doctors approved patients to hospice case based on the admission nurses' evaluation. CW10 confirmed that this also occurred for crisis/continuous care patients – while physicians must refer patients, patients cannot be admitted without the admission nurse first assessing that they have met the criteria for continuous care.

74. While serving as an admitting nurse at VITAS' Dublin, Ohio facility, CW6 stated that there was constant pressure from sales staff to admit patients who were ineligible for hospice care. In cases where CW6 evaluated a patient, determined that the patient did not qualify for hospice care and recommended against enrolling that patient, CW6 was badgered by the sales manager, Cristal Schmit, and general manager, Steve Wishart, regarding his recommendation. A second admitting nurse would then be sent to reevaluate the same patient, and the patient would subsequently be admitted. According to CW6, other admitting nurses experienced similar pressure to admit ineligible patients into hospice care.

75. Former VITAS admitting nurse, CW5, confirmed that the practice of reexamining a patient after the patient was found to be ineligible for hospice care by a different admitting nurse

[3] Constant, strong pressure was also put on doctors to certify and recertify patients who did not meet Medicare eligibility requirements. *See* ¶197.

"happened quite frequently" during his tenure. Former marketing sales representative, CW11 also stated that his location the director of marketing and the patient care administrator would send the same nurse out multiple times to visit the same patient in order to find a diagnosis allowing the patient to be brought on to hospice care. Former patient care administrator, CW3, similarly noted that, during the Class Period, there was a practice and procedure in place by VITAS management to overturn decisions made by admitting nurses who denied a patient hospice care. When this happened, the general manager or marketing director would contact team physicians to provide them with other qualifying facts supposedly not considered by the admitting nurse, which led to the admission of the patients in question.

76. The DOJ Complaint also cites this practice, describing reports of "Medical staff … that . . . felt pressured by Vitas to admit or readmit patients who were inappropriate for hospice services. One former Vitas admissions nurse said that if he did not admit a patient he believed to be ineligible, he would be pressured to reconsider his decision until he finally determined the patient was eligible for the Medicare hospice benefit. The same nurse stated that he was pressured by Vitas to bend the Medicare rules to get patients onto hospice service." DOJ Complaint ¶173.

77. CW15 explained that admission nurses had to recommend admission of 80% of the patients they evaluated to keep their jobs, as well as earn a merit increase. If they did not recommend the admission of 80% of the patients they evaluated in their first 90 days of employment as an admission nurse, they would either be fired, offered another job (such as a home care nurse), or be transferred to the overnight shift which would often induce them to quit. This happened to CW6. His general manager, Wishart, did not approve of CW6's determination to not admit ineligible patients, and retaliated by altering his work schedule.

78. CW10 stated that nurses would "get a lot of heat" if they did not admit patients because "it was all driven by bonuses," adding that the admissions manager and general manager

were on bonus programs. According to CW10, even under circumstances outside of the admission nurses' control, the nurses would be reprimanded for not admitting enough patients. CW19, an admissions manager, confirmed that monthly quotas had to be met and that the overwhelming pressure to achieve census numbers was a cause of CW19's departure.

79. CW13 personally witnessed personnel challenging admission nurses who determined that a patient was not terminally ill and was not qualified for hospice care. He recalled one specific example in which patient care administrator, Evalisa McClure, challenged an admitting nurse for denying hospice care to a patient who the nurse determined did not meet the admitting criteria. CW13 stated that it was not the patient care administrator's responsibility to challenge the admitting nurse on criteria, and added that "it seemed unethical." CW11 also overheard the director of marketing, Mary Beth Wadding, and patient care administrator, Anne Beamesderfer, chastise nurses for failing to admit patients into hospice care. CW20 stated that the inpatient unit manager, Fitzmaurice, would instruct the RN's to go through the patient's chart to find something and anything that they could use to make it seem as if the patient met CMS guidelines for inpatient care. CW20 stated that it seemed to her and the other inpatient RN's that the home care side was charting these patients to make it appear as if their health was worse than it really was in order to get them into the inpatient unit. An example that CW20 provided was a patient whose chart stated that the patient was "in pain and anxious," but the patient was not in pain and did not seem anxious when arriving to, or while in, the inpatient unit.

80. CW12 also stated that nurses were under pressure to admit patients who did not qualify for hospice care and that as a result, VITAS admitted patients inappropriately. CW12 heard admission nurses and registered nurses often complaining about being pressured to admit inappropriate patients and that every employee, including nurses, marketers, and telecare workers, was encouraged to admit as many patients as possible. CW12 recalled an instance when an

admitting nurse was literally crying to him over being pressured to admit an inappropriate patient that the admitting nurse refused to admit. CW12 also recalled another situation where Dayiantis, the telecare services general manager, instructed an admissions coordinator in the Lombard, Illinois office on how to apply pressure and convince admissions nurses to admit patients. The pressure was so intolerable that, according to CW12, admitting nurses sometimes evaluated patients without their family's knowledge. This would anger the patient's family, who would complain that VITAS admitted their non-terminally ill family member to hospice care. CW12 had actual knowledge that patients' families were upset since he and other admissions coordinators would field their phone calls. CW12 added that doctors were also upset, and questioned why ineligible patients were being admitted to hospice care.

81. The DOJ Complaint details specific examples of VITAS doctors who recommended *against* admitting certain patients being overruled by VITAS administrators. "One Vitas team doctor stated that on several occasions, when he did not believe patients were eligible for hospice, and therefore did not certify the patients as eligible, the Vitas medical director overruled him and signed the certification even in the absence of justification. A former Vitas physician stated that he was under pressure from Vitas management to increase the number of patients admitted to hospice, and that he was often overruled when he determined that a patient should be discharged because the patient was not dying. This physician informed Vitas managers that he was concerned that his medical decisions were being ignored, but Vitas did not address his concerns." DOJ Complaint ¶¶176-77.

82. CW12 stated that "there was a big push on numbers." CW12 stated that the nurses were often hard pressed to find an admitting diagnosis that met criteria and he noticed that often times a patient's charts did not properly memorialize the admitting nurse's diagnosis. One such example was of an Alzheimer patient whose diagnosis would not meet, or at least was not

documented as, an end stage diagnosis. When CW12 would notify his supervisors, Lipinski and DeGrazia, that a patient's chart was inconsistent with the admitting nurses' diagnosis, they both replied, "get them on, no matter what." CW12 added that similar pressure was placed on all telecare workers, nurses, and marketers and that both Lipinski and DeGrazia stated that this was as per Dayiantis's orders. CW12 would be instructed to transfer the patient to hospice and he would do so by entering the "Transfer to Patient Care" setting in the computer system. CW12 added that "it was all about meeting the numbers," and was instructed to not ask questions and just transfer the patient. CW20 confirmed that when the inpatient unit census was low, that patients were being referred from the hospital and the field who did not match the symptoms in their charts. She recalled "diarrhea patients" who showed up without having diarrhea and "respiratory distress patients" showing up without respiratory distress. CW20 stated that she and the other inpatient unit RN's spoke about the inappropriateness of these patients, as did inpatient unit manager Fitzmaurice. CW20 added that Fitzmaurice had stated, "Some of these patients were inappropriate."

83. CW12 also described how VITAS pressured nurses and doctors at nursing homes to transfer patients to hospice care. CW12 stated that an admission nurse would fill out a transfer order on a patient, travel to the nurse's station at a nursing home, and ask the nurse to have the doctor sign the order. If the nurse refused because the patient did not require hospice care, then the admissions manager would constantly call the nurse at the nursing home for a transfer order until either the nurse had the doctor sign the order, or left the order in the patient's file until the doctor signed it. According to CW12, the objective was to keep pestering the nurse until the doctor eventually signed the transfer order, either out of frustration, or possibly not realizing what exactly he was signing due to the volume of paperwork requiring his signature.

84. The DOJ Complaint supports the veracity of these CW accounts. "According to one former hospice manager for Vitas, the company philosophy was to sign everybody up for Medicare

hospice services. A former Vitas nurse in Florida said that Vitas wanted everyone enrolled in hospice care. This philosophy is inconsistent with Medicare requirements, because, for example, a patient who elects hospice care under the Medicare program also chooses to stop receiving curative care for his or her illness." DOJ Complaint ¶172.

85. CW14 described "general debility" and "failure to thrive" as "catchalls" to admit patients who were either questionable or did not satisfy admission criteria. CW14 recalled hearing admission managers, nurses, and the regional director of marketing, Merritt, state that "if you can't find anything (to admit a patient), then use 'failure to thrive.'" CW14 advised that this was stated at weekly meetings attended by Acocella (who reported to Vice President of Market Development and Sales, Donald Gaddy. Gaddy reported directly to Defendant O'Toole), Boulter, physicians and marketers. CW14 added that in these meetings, nurses posed questions regarding the discharge of patients diagnosed with dementia and Alzheimer's who had been on hospice care for 3 or 4 years. The nurses were instructed by Acocella and Boulter to find a reason to keep them in hospice care. CW14 stated that patients diagnosed with dementia and Alzheimer's who did not meet criteria were admitted to hospice care under the "failure to thrive" diagnosis.

86. Many of these patients were admitted at the end of the month because, as CW11 confirmed, there was a focus to meet monthly census or admission goals, and that VITAS nurses would look for any diagnosis to get patients on hospice. CW19 confirmed that during the last week of each month, the pressure to admit patients into hospice care, whether they qualified for Medicare reimbursement or not, was intense. CW14 also confirmed that admissions increased at the end of the month. CW20 stated that "when the census was low, it seemed we took any patient." CW14 described the number of inappropriate patients as being fairly significant, especially amongst the dementia and Alzheimer's patients. CW15 confirmed VITAS would select general debility and

failure to thrive as the diagnosis code for Alzheimer's or dementia patients who did not meet the admission criteria.

87. Former VITAS registered nurse, CW7, similarly reported that, throughout his tenure, pressure was placed on admitting nurses to admit inappropriate patients for hospice care at VITAS. Many of these inappropriately admitted patients were diagnosed as "debility unspecified" and received VITAS' hospice services for periods of one to two years. CW7 stated that when it came to referrals, VITAS took a "we'll take anything" approach.

88. CW11, a former sales representative, confirmed that admission nurses were under intense pressure to admit patients and search for any diagnosis in order to admit patients into VITAS' hospice care. CW11 stated that the admissions nurses would diagnose patients as "general debility" if they could not find another diagnosis. CW4 confirmed that inappropriately admitted patients were diagnosed with dementia or Alzheimer's, or were categorized as "failure to thrive" or general debility.

89. CW15 stated that VITAS admission nurses would "manipulate a patient's information" to certify that the patient met hospice criteria even if the patient was not quite hospice-appropriate. CW15 provided examples of overstating an Alzheimer or dementia patient's forgetfulness and recording an inaccurate reading of a patient's blood pressure.

90. The DOJ Complaint also details how nurses were coerced into falsifying information. A "Vitas nurse stated that she was instructed by Vitas to falsely write that a patient experienced symptoms that the patient did not experience in order to support a determination of hospice eligibility. For example, she was once told to write that a patient had an unnatural color, or pallor, when the patient did not, and was instructed not to write that the patient's health was improving in the medical record." DOJ Complaint ¶175.

91. The DOJ Complaint confirms that this pressure was coming from "top-level management" at Chemed and VITAS. "Top-level managers at Vitas's corporate headquarters set aggressive hospice admissions goals for regional and mid-level corporate managers at local Vitas programs, resulting in the admission of ineligible patients. Chemed management regularly corresponded with Vitas management about the average daily census and growth in admissions, making focused frequent inquiries if they believed the numbers reported were too low. Vitas senior managers regularly corresponded with personnel in the field offices when their average daily census and admissions growth were lagging." DOJ Complaint ¶¶160-62.

92. The fraud also extended beyond the admission of patients who did not qualify for hospice care. VITAS also pressured its employees to recertify patients for hospice care even when they no longer qualified. CW9, an admissions nurse and case manager, witnessed inappropriate dementia patients who remained in hospice care at VITAS for 2 or 3 years. CW9 and others "scramble[ed] to find [a] diagnosis" to attribute to these dementia patients so that they would qualify for and remain in hospice care. CW3 stated that at team meetings – whose purpose was to evaluate patient charts for possible recertification – there would be discussions concerning the fact that patients were no longer appropriate to recertify. CW3 stated that team physicians ended up resigning because of the pressure to recertify inappropriate patients. "They didn't want to have their name on something where the patients weren't appropriate."

93. CW18 corroborated this, stating that he observed inappropriate patients provided with hospice care. When he or other social workers, or other nurses would state their opinion as to the inappropriateness of certain patients in team meetings, the response from team managers would often be to keep the patient on for 3 months until the recertification period to determine whether the patient's health deteriorated. As set forth in the DOJ Complaint: "[a]nother Vitas nurse stated that when she attended the weekly meetings to discuss discharging patients, the goal was to discharge as

few patients as possible without regard to hospice appropriateness. Discharging more than four patients per meeting was frowned upon by the Vitas business managers, and Vitas medical staff were told to stop discharging patients even if patients were not eligible." DOJ Complaint ¶174.

3. VITAS Pressures Marketers to Push for Inappropriate Admissions

94. In addition to the pressure placed by VITAS on admitting nurses to admit ineligible patients, pressure was also placed on other VITAS employees. Among those pressured and incentivized to admit patients into VITAS' hospice care programs were general managers and their sales and marketing staffs. As the DOJ observed, "[g]eneral managers, who were typically not nurses or doctors, expected their marketing departments and sales representatives to find referral sources and patients, and evaluated and promoted their employees based on meeting hospice admissions goals. This often meant that the Vitas program managers disregarded concerns of nurses and doctors who expressed that they did not believe that certain Vitas hospice patients were terminally ill." DOJ Complaint ¶166. These general managers were directly evaluated based on the number of patients admitted at the program facility and the profitability of those patients. *Id*. at ¶165.

95. Severe pressure was placed on VITAS' marketing personnel by general managers to improperly admit patients into hospice care in form of monthly and quarterly quotas that came from the top level of the Company. CW14 described Senior Vice President of Market Development and Sales, Donald Gaddy (who reported directly to Defendant O'Toole), as "running the show" and believed that he most likely generated monthly and quarterly quotas. CW4 confirmed this stating that the push on quotas was coming from Gaddy, and that Regional Director of Marketing, Kim Lowerman, received the quotas from Gaddy and then sent them out to the marketers. According to CW1, the quotas were set by Defendant O'Toole. It was CW1s understanding that Gaddy and

Executive Vice President Peggy Pettit (who reported directly to O'Toole) were also involved in setting the quotas.

96. VITAS' quota system created incentives for marketing personnel to not only generate referrals for VITAS, but to also ensure that those referrals turned into actual patients. According to CW8, to meet VITAS' company-wide quota, 80% of a marketer's referrals had to be admitted into VITAS' hospice services. Marketers received bonuses for meeting quota. Quotas increased exponentially as admissions rose above the 80% quota level. The DOJ Complaint supports these allegations, alleging that "[o]ne former general manager stated that Vitas paid him bonuses based on the number of patient admissions and the length of time he could get a patient to stay on hospice services." DOJ Complaint ¶¶167-68.

97. CW11 also noted that if marketers did not meet their quotas, they were penalized. CW4 confirmed this, stating that he was terminated because his team did not meet monthly quotas. Marketer's compensation was boosted when the number of leads and actual patients exceeded the quota and, if quotas were not met, marketers were fired.

98. CW14 corroborated that marketers had to meet their monthly quota in order to get a bonus and to avoid getting written up. CW 15 also stated that marketers had monthly quotas and that these quotas were distributed quarterly. CW15 advised that each marketer had to have 80% of his monthly referrals converted to admissions in order to get a bonus and to avoid getting written up. CW15 added that VITAS "made life miserable (for you) if you didn't meet the numbers." CW16 stated that marketers at his location were expected to obtain admissions and not just referrals. CW16 recalled an instance when he had made 22 referrals in one month, but only 7 were converted into admissions, and as a result, was written up because of that percentage. He advised that, "it was not the referrals, but the admissions that counted." CW1 and CW8 echoed this sentiment and stated that compensation was based on actual admissions and not referrals. The DOJ reached a similar

conclusion: "Vitas took adverse employment actions against marketing representatives who did not meet monthly admissions goals." DOJ Complaint ¶168.

99. CW12 stated that marketers would harass families until they obtained approval to place a patient into hospice care. CW12 also stated that marketers would pressure nurses, and as a result of this pressure that nurses would draft orders transferring patients onto hospice and pressure doctors to sign the orders. Doctors would sign-off on orders to stop being pressured by nurses.

100. Although VITAS' marketing personnel were not supposed to play a role in the admissions decision-making process, CW3 confirmed that VITAS' marketing personnel often became involved in the admissions process and would speak with patients' families to persuade them to use VITAS' hospice care services.

101. This was corroborated by CW14. According to CW14, both Boulter (director of marketing development) and Acocella (program general manager) worked closely in enrolling patients, Boulter and Acocella "followed the numbers," and instructed marketers to pressure admission nurses and physicians by constantly calling them and asking when a patient would be admitted. CW14 stated that there was "always a push to get patients on." CW14 advised that when marketing home hospice care, marketers would promote VITAS' services to nursing home physicians by pointing out that Medicare covers the patient's medication while enrolled in hospice care, and that this would have financial benefits for nursing homes who were no longer receiving Medicare money for that patient's medication. CW14 stated "we (hospice) pay for your (patient's) medications. They (Medicare) don't pay for your (patient's) medications." CW6 also understood that sales people were not supposed to influence the admissions staff, but that was not the case in his office. According to CW6, "the sales manager actually runs th[e] office."

102. CW15 similarly stated that many of VITAS' marketers who he worked with were former admission nurses who switched to marketing because of the higher income. CW15 added that

these marketers would then simultaneously act as a marketer and admission nurse when placing marketing calls.

103. CW16 confirmed that marketers were "absolutely" putting pressure on admission nurses to admit patients. CW16 said that both Boulter and Cutler directed him and his fellow marketers to call and visit admission nurses and physicians and ask if and when referred patients would be admitted. If the admitting nurse or doctor made a preliminary decision not to admit a patient, he was told to then ask "why," as well as ask other follow up questions. CW16 advised that these were not fact-finding questions, but rather were posed in order to pressure nurses and physicians to admit patients. CW16 added that in meetings attended by Merritt, both Boulter and Cutler stated "this is how VITAS does it."

104. CW13 described pressure placed on him by VITAS marketers in the referral of patients receiving palliative care to hospice care. CW13 stated that hospice marketers would call him stating that "it looked like a patient was ready for hospice care." CW13 explained that in many cases the patient was not ready for hospice care, and that he would inform the marketer of his opinion. He added that "I knew that their jobs were on the line because of the numbers." CW13 advised that both Katich and hospice admissions manager, Jayne Clements, stated to him that "palliative care services was measured by success on how many patients were referred to hospice."

105. CW3 stated that, during the Class Period, even when admitted patients were up for recertification of hospice services and physicians were ready to discharge patients who no longer qualified, VITAS' sales staff, who were also present at the meetings, would intervene by somehow obtaining documentation showing that the patients were appropriate for recertification. According to CW9, during interdisciplinary team meetings, team members were instructed by Gail Hart to find any medical criteria that would allow non-declining patients to remain in hospice.

106. The DOJ Complaint supports the accounts of the CWs regarding the aggressive sales goals set for the Company's sales staff, stating "Chemed and VITAS set aggressive sales goals for the number of crisis care days that it wanted Vitas to bill to Medicare, and was directly involved in making decisions about how Vitas would market its crisis care services. As a result, Chemed and Vitas set aggressive goals for Vitas's salespeople and other staff to find beneficiaries for whom they could bill Medicare for crisis care, and Vitas billed Medicare excessively for crisis care." DOJ Complaint ¶¶65-66. Aggressive marketing tactics were endorsed by Chemed and VITAS, which "expected their employees to increase the number of crisis care claims submitted to Medicare, without regard to whether the crisis care services were appropriate for patients, or whether Vitas was actually providing the crisis care services to patients when it billed Medicare for those services." *Id.* at ¶57.

4. VITAS' Pressure on Nurses and Marketers Results in Inappropriate Admissions to Hospice

107. Chemed and VITAS' plan worked. The intense pressure placed on admission nurses to evaluate patients and find them eligible for hospice care, and on marketers to push admitting nurses and doctors to admit the patients they referred, resulted in the widespread inappropriate admissions of patients for both hospice care and continuous home care. The increase in admissions numbers reflect both the pressure placed on admitting nurses and marketers, and the success of that pressure. Former employees throughout the country confirmed with specificity the percentage of patients admitted to VITAS' hospice care who did not qualify under Medicare's rules and regulations.

108. According to CW3, at least 50% of admitted patients in VITAS' Dublin, Ohio facility did not qualify for hospice care. CW3 personally conducted an audit of patient lists and charts during the Class Period to verify patient eligibility and found that documentation was not satisfactory. CW3 reported the improper admission of patients to general manager, Steve Wishart, to

the Regional Nursing Supervisor, and directly to the Vice President of Operations, Joanne Mack. Joanne Mack reported to Karen Peterson, the Chief Nursing Officer. Peterson, in turn, reported directly to O'Toole.

109. CW3 recalled a specific instance where he was told to admit a patient who was unconscious and unable to consent to hospice services. When CW3 refused, the general manager notified Joanne Mack, who authorized the admission. CW3 eventually resigned his position with VITAS because of the improper admission of ineligible patients at the Dublin, Ohio facility and sent a letter directly to Tim O'Toole and Karen Peterson (the Chief Nursing Officer, who reports to O'Toole), at VITAS' corporate office detailing all the admissions issues that he observed. CW3 knows that the corporate office received the letter because a VITAS attorney, a corporate representative and Karen Peterson contacted him about the letter and notified him that they would investigate his allegations. They conceded that the non-responsive patient admitted by Joanne Mack should not have been admitted. CW3 stated that several physicians ended up resigning as well because they did not want to have their names associated with these improper practices.

110. According to CW7, approximately 20% of the hospice patients in VITAS' Coachella Valley, California location were inappropriately admitted.

111. CW5 estimated that 70% of the dementia patients she observed under VITAS' hospice care in Sacramento, California did not meet hospice care admissions criteria.

112. CW12 estimated that 30% - 40% of the VITAS patients serviced out of the Lombard call center were inappropriate for hospice care based on the patients' charts that he evaluated. He added that "there were at least 7 charts per 8 hour shift that did not seem right." CW12 indicated that there were patients on VITAS hospice care for 2 to 3 years and stated that "there were referrals that seemed to come from nowhere."

113. CW15 estimated that 10% of VITAS' patients were inappropriate for hospice care, many of them being Alzheimer's and dementia patients. CW15 stated that 80% of Ft. Lauderdale's hospice patients were Medicare recipients, with anywhere from 25% - 50% being Alzheimer's and dementia patients. CW15 added that some Alzheimer's patients were in hospice care for 2 or 3 years.

114. According to former Director of Market Development, CW4, approximately 10% of VITAS' hospice patients were admitted inappropriately for at least one 90 day certification period. CW4 explained that the objective was to get the patients through the first certification period and see if they got progressively worse during that time. CW4 also observed that the admission of patients increased at the end of each month, since the General Manager of Operations put pressure on admissions personnel to enroll more patients to meet the General Manager's monthly sales goals.

115. CW14 (like CW12, ¶81) also stated that there was a "a big push on numbers" and that more patients were being admitted at the end of each month in order to meet quotas.

116. CW15 stated that admitting nurses would admit patients into hospice care who were not yet eligible but who were expected to qualify within a few days. CW15 provided an example of an admitting nurse who would admit a patient on a Monday and then re-evaluate the patient on Thursday. If the patient's health deteriorated by that time, then the patient would remain in hospice care. If the patient's condition did not deteriorate, then VITAS would discharge the patient, stating that the patient's health had improved. CW15 stated that VITAS billed Medicare for the days such patients were in hospice care.

117. The DOJ, which was empowered by different courts to conduct pre-suit discovery, identified several examples of *specific patients* who were inappropriately admitted to hospice care. The DOJ Complaint states that Chemed and VITAS fraudulently billed Medicare for these patients, including patients who were improperly admitted for hospice care before, during and after the Class

Period. The following patients were inappropriately admitted into hospice care and VITAS fraudulently billed Medicare for these patients:

(a) "MP" from Missouri – according to the DOJ, "Chemed and Vitas knowingly submitted or caused to be submitted false or fraudulent claims to Medicare for hospice care for Patient MP in Missouri from April 10, 2009 through February 3, 2010. These claims were false or fraudulent because Vitas's medical records for MP show that MP did not have a terminal illness with a prognosis of six months or less if MP's disease ran its normal course. According to Vitas's medical records, Vitas admitted MP to hospice based upon a diagnosis of debility, but MP did not meet the medical criteria for this diagnosis. In addition, on April 10, 2009, the day MP was admitted to hospice, there was no indication that MP's pre- existing condition had deteriorated. The medical records state that MP was alert and oriented to self, denied pain, and weighed 151 pounds, having only lost two pounds in the last one to two months. Throughout the period that Medicare paid Vitas's claims on behalf of MP, Vitas's medical records show that MP remained stable and even gained weight, and her body mass index remained consistently above the level required by hospice eligibility criteria . . . Chemed and Vitas knowingly submitted or caused the submission of false or fraudulent claims to Medicare for hospice care on behalf of patient MP from April 10, 2009 through February 3, 2010, in the amount of $42,763.82; and Medicare paid the claims." DOJ Complaint ¶¶187-90.

(b) "MC" from California – as related by the DOJ, "Chemed and Vitas knowingly submitted or caused to be submitted false and fraudulent claims for hospice care on behalf of Patient MC in California, covering the period from July 18, 2009 through February 16, 2012. These claims were false or fraudulent because Vitas's medical records for MC show that MC did not have a terminal illness with a prognosis of six months or less if MP's disease ran its normal course. Vitas's medical records for MC also show that at each period of time when Vitas recertified that MC was

eligible for hospice care, MC did not have a terminal illness with a prognosis of six months or less if MC's illness ran its normal course. According to Vitas's medical records, Vitas admitted MC to hospice after a hospital stay, based upon a diagnosis of heart failure, but MC had no symptoms to indicate MC had any end-stage disease or condition, including heart disease. At the time of MC's admission to the hospital, MC was living independently and performing daily activities without assistance. At around the time Vitas admitted MC to its hospice program, its medical notes for MC stated that MC was very healthy given her age. In fact, Vitas stopped administering MC heart medications during her time in hospice. During MC's hospice stay, the only medications that Vitas administered were for anxiety. MC was walking and performing daily activities without assistance. In March 2010, a doctor noted that MC did not need oxygen, unless she became excited. Any shortness of breath was related to MC's anxiety, not heart disease. In addition to improperly admitting MC for hospice care when she was not eligible, Chemed and Vitas also knowingly submitted or caused to be submitted false or fraudulent claims to Medicare on behalf of MC for crisis care. On January 20, 2012, Vitas began billing Medicare for crisis care for MC due to caregiver teaching and breakdown, neither of which are bases to submit claims to Medicare for crisis care. During the time that Vitas billed Medicare for crisis care for MC, Vitas's nursing notes state that MC was doing her own laundry. Vitas stopped billing Medicare for crisis care on January 24, 2012 for unspecified reasons. MC died on February 16, 2012, after being on hospice for approximately two and a half years. Although MC died while receiving hospice, at no point during the time that Vitas billed Medicare for MC's hospice care did MC have a life expectancy of six months or less if a disease ran its normal course. Chemed and Vitas knowingly submitted or caused the submission of false or fraudulent claims to Medicare for hospice care on behalf of Patient MC from July 18, 2009 through February 16, 2012, in the amount of approximately $169,820.99 and Medicare paid the claims." DOJ Complaint ¶¶199-209.

(c) "WB" from California – according to the DOJ Complaint, "Chemed and Vitas knowingly submitted or caused to be submitted false or fraudulent claims to Medicare for hospice care on behalf of Patient WB in California, covering the period from June 5, 2008 through March 18, 2011. These claims were false or fraudulent because Vitas's medical records for WB show that WB did not have a terminal illness with a prognosis of six months or less if WB's illness ran its normal course. Vitas's medical records for WB also show that at each period of time when Vitas recertified that WB was eligible for hospice care, WB did not have a terminal illness with a prognosis of six months or less if WB's illness ran its normal course. According to Vitas's medical records, Vitas admitted WB to hospice based upon a diagnosis of cardiovascular disease, but there were no medical examination findings to support the conclusion that WB was in end-stage heart failure or had another end-stage cardiac condition, and Vitas did not accurately assess whether WB had a terminal illness with a prognosis of six months or less if WB's illness ran its normal course. A patient with a cardiac disease can be terminal if the patient meets the criteria for Class IV on the New York Heart Association's system for classifying degrees of heart failure. To be Class IV, a patient must be unable to carry out any physical activity without discomfort, have symptoms of cardiac insufficiency while at rest, and experience increased discomfort if the patient engages in any physical activity. Vitas's records for WB show that he had no shortness of breath or other heart failure symptoms while at rest. Additionally, Vitas gradually decreased the heart medications that WB received while he was on hospice care, finally ceasing all of WB's heart medicines on December 20, 2009. Throughout his time on hospice, WB remained stable and was clearly not suffering from end-stage heart disease. Vitas's medical records for WB contained inconsistent and contradictory information, including inconsistent descriptions of WB's symptoms written by different members of Vitas staff as well as inaccurate functional scores noted by Vitas staff but contradicted by WB's documented symptoms. For example, nursing notes in WB's medical files would state that WB had no shortness

of breath, but a doctor who visited WB around the same time wrote that WB had intermittent shortness of breath. Additionally, Vitas staff noted in WB's records that he was experiencing slow progressive decline and remain[ed] appropriate for hospice with prognosis of 6 [months] or less, Vitas's records for WB lack any documentation of decline in WB's nutritional or functional status, or other factors that would indicate that WB had a prognosis of six months or less if his disease ran its normal course. After remaining stable while he received hospice care for almost three years, WB was ultimately discharged from hospice on March 2, 2011 for extended prognosis. Chemed and Vitas knowingly submitted or caused the submission of false or fraudulent claims to Medicare for hospice care on behalf of Patient WB from June 5, 2008 through March 18, 2011, in the amount of $170,666.02; and Medicare paid the claims." DOJ Complaint ¶¶191-98.

5. VITAS Inappropriately Admits Patients to Continuous Care

118. According to CW10, a former admissions nurse at the Walnut Creek, California location of VITAS, "continuous care" was routinely ordered for all new VITAS patients seeking hospice care after being discharged from a hospital, even when this level of care was not required. When a hospice patient is given "continuous care," which should be provided only during a period of crisis, he or she receives a minimum of eight hours of hospice care during a nurse's home visit. According to CW10, both Jill Heifetz, CW10's admissions manager, and Bruce Davis, the general manager of the Walnut Creek, California facility, stated that the policy to admit all patients discharged from a hospital into the more expensive "continuous care" level of hospice care had "com[e] down from corporate," and that the goal was to place 5 or 6 referred hospital patients into continuous care each day. While VITAS billed Medicare for a minimum of 8 hours for the home visit, CW10 stated that nurses provided about one hour of actual care. According to CW10, approximately 50% of the hospital-referred patients did not require hospice care at the "continuous care" level. CW10 stated that admission nurses would admit inappropriate patients into continuous

care because the admission nurses "were following orders under the policy that all hospital patients should go to continuous care."

119. CW15 stated that VITAS used the promise of continuing care to add hospice care customers. He explained that VITAS would offer continuous care to patients as round-the-clock care, but that once the patient was enrolled, VITAS would then transfer the patient to general hospice care after approximately 48 hours, claiming that the patient no longer required continuous care. CW15 indicated that the patients' families would often become upset, feeling that they had been led to believe that if they enrolled their relative in VITAS continuing care, their family member would receive continuous care for a longer period of time. CW15 stated that some families who felt misled would transfer their relative from VITAS to another hospice, but that most would just remain with VITAS. CW11 confirmed that continuous care was a major component of VITAS' marketing effort.

120. CW17 explained that VITAS and other hospice care providers were only supposed to provide continuous care during a period of crisis. CW17 estimated that 15% - 20% of his patients, at both the Chicagoland NW and Chicagoland Central locations, were inappropriately admitted for continuous care with a diagnosis such as failure-to-thrive, dementia or Alzheimer's. He added that many of these inappropriately admitted patients were "repeat patients" in that their conditions would improve and then they would be readmitted onto continuous care months later.

121. CW17 advised that continuous care was supposed to be only for those hospice patients who are in need of hospice care 24 hours a day, seven days a week. He recalled caring for VITAS continuous care patients at private homes who could sit up, talk coherently, feed themselves, walk on their own and bathe themselves. One patient attended a baseball game, and other patients asked CW17 to take them shopping (which he refused to do). CW17 specifically recalled one particular time when, upon arriving to care for a patient, a family member explained to him that the

patient was tired from shopping all day. CW17 stated that these inappropriately categorized patients had lucid conversations with their family and friends, and he described his responsibility in these circumstances as "babysitting while watching television." CW17 advised that his normal 13-hour shift as a continuous care nurse normally started at 7:00 p.m. and ended at 8:00 a.m.

122. CW17 stated that the continuous care team was instructed to reevaluate its diagnosis when a patient showed improvement. CW17 stated that "we would document change in any way that allows us to keep that patient on." For example, CW17 described a patient with pneumonia and, once his lungs healed, the continuous care nurse was told to document that the patient had problems walking or talking. CW17 stated that after a failure-to-thrive patient started eating again and regained his health the continuous care nurse was expected to document that the patient seemed more confused or to provide any other reason to keep the patient in continuous care. CW17 described it as "if you can't keep them on for one thing, then you find a new diagnosis."

123. The DOJ Complaint cites similar instances of abuse of continuous or "crisis" care billing. "Vitas marketed crisis care services to patients and their families as intensive comfort care services, without mentioning that in order to bill Medicare for these services at the higher rates, a patient had to be experiencing a short-term crisis and have acute medical symptoms. One of Vitas's marketing brochures states that 'intensive comfort care' is available for 'symptoms causing distress to the patient or family.' Vitas knowingly misled patients and their families to believe that the Medicare hospice benefit would routinely cover around-the-clock care for hospice patients, absent the requisite acute medical symptoms resulting in brief periods of crisis that must be present for crisis care to be covered by Medicare. Because of this marketing ploy, patients sometimes chose Vitas over other providers, although the Medicare benefit is the same for patients regardless of the hospice program they choose. Vitas used similarly misleading techniques when it marketed its

hospice services to potential referral sources of future hospice patients, such as physicians, nursing homes, and hospitals." DOJ Complaint. ¶¶58-59.

124. Detailed allegations from the DOJ Complaint demonstrate that Chemed and VITAS inappropriately admitted patients to continuous care and illegally billed Medicare for these inappropriate admissions during the Class Period. DOJ Complaint ¶¶9, 54, 186. For example, the DOJ Complaint describes how VITAS billed Medicare for "patient MG" in California for unnecessary crisis care during the time period from February 19, 2010 through March 8, 2010. "According to its medical records, Vitas billed Medicare for crisis care for MG beginning on February 25, 2010, and ending on March 8, 2010, for the stated reason of seizures. However, Vitas's records do not indicate that MG suffered seizures during this time period. MG was not otherwise in crisis during this time period. Vitas should not have billed Medicare for crisis care when routine home care was appropriate. Chemed and Vitas knowingly submitted or caused the submission of false or fraudulent claims to Medicare for crisis care services to Patient MG that were not necessary or not provided for the time period February 25, 2010 through March 8, 2010, in the amount of approximately $5,000; and Medicare paid the claims." DOJ Complaint ¶¶151-53.

6. VITAS' Inappropriate Relationships with Nursing Homes and Doctors

125. Several former VITAS employees also reported that, in order to increase hospice admissions, VITAS engaged in improper relationships with various referral sources. According to CW7, for example, it was the practice of VITAS to transfer patients from the hospital to VITAS for hospice care when coverage from Medicare was running out. Once admitted to VITAS, the patients' Medicare coverage for hospice care began. CW7 described such a relationship between VITAS and Desert Regional Hospital. CW3 also reported a reciprocal relationship between VITAS and Woodlands Assisted Living facility during the Class Period. According to CW3, out of approximately 20 VITAS patients at Woodlands, only about 2 qualified for hospice services and

many of these patients had been in hospice care for over one year. While Medicare did not pay for assisted living at facilities such as Woodlands, it covered hospice services. Accordingly, VITAS benefitted from Woodlands' patient referrals. In turn, Woodlands benefitted from having hospice patients continue to pay room and board, while being cared for by hospice nurses, freeing up staff to tend to other residents.

126. The director of nursing at another assisted living facility, Deer Creek on Hillsboro Blvd. in Deerfield Beach, Florida, told CW15 that if VITAS would have their nurses, while in the course of visiting their patients at Deer Creek, help out with patients who were not VITAS patients, that he would recommend VITAS to their patients and their families for hospice care much more often. CW15 advised that he brought this request to Deal who gave the okay on this and instructed CW15 to advise team leader Terri Sande that VITAS nurses should now assist Deer Creek nurses with their other patients when visiting VITAS' patients. CW15 stated that general manager Zalaznik must have given approval on such a decision and added that "Deal didn't pick his nose without first asking Zalaznik."

127. According to CW15, *referring* physicians were paid $350 to review a patient's chart, and an additional $350 for reviewing a chart for recertification, whether the patient was recertified for hospice care or not. Most of the time the patient would receive approval for admission or recertification. CW15 was told about these payments by Dr. Gabriel Gemayel of Palm Beach County. CW15 stated that Dr. Gemayel was a physician who he marketed to and who referred patients to VITAS.

7. Defendants Knowingly Violated Medicare Billing Practices

128. Defendants' knowledge of VITAS' illicit admission of patients into hospice care who did not qualify, provision of continuous care services to patients whose condition did not so warrant, and manipulated billing practices is clear. Defendants actively managed VITAS' business,

overseeing and monitoring VITAS' productivity, admissions levels, discharge rate and length of patient stays. *See* ¶¶61-63.

129. Moreover, Defendant O'Toole not only imposed unreasonable census goals, but knew that the results he received from the various hospice facilities were inflated with inappropriate admissions. *See* ¶¶61, 95, 108. In light of their intimate involvement with VITAS' activities, Defendants knew that VITAS' patient admission, patient retention, continuous care offerings and billing practices violated applicable Medicare regulations and resulted in the Company materially overstating its revenues based on hospice services rendered to ineligible patients.

130. The DOJ Complaint provides additional evidence that Defendants knew that patients were being inappropriately admitted to hospice care for continuous or crisis care. Since at least 2007, Chemed and VITAS conducted regular internal audits or program reviews. "Through these internal audits, Chemed and Vitas were made aware of patients (1) who were receiving crisis care services, but did not qualify for such services, (2) for whom services were billed to Medicare as crisis care services, but the services were inconsistent with the patients' medical plans of care or with Medicare requirements, (3) for whom Vitas's own medical records showed were not in crisis." DOJ Complaint ¶¶68-69.

131. The DOJ Complaint references an internal Company document written during the Class Period, in September 2010, entitled, "Patient Care Documentation and Compliance Internal Review" for the San Fernando, California VITAS hospice program, showing that VITAS reviewed crisis care medical records for this hospice program. "Only 50 percent of the records showed that Vitas was being consistent with Medicare's criteria for crisis care. Only 10 percent of the crisis care claims comported with the patients' plans of care set forth by Vitas medical teams. After reviewing multiple factors, the audit team gave the crisis care claims in this location a 69 percent score, indicating a significant deficiency in compliance with Medicare requirements." DOJ Complaint ¶70.

CW3 confirmed that during his tenure, Chemed sent a representative to perform an audit on patient charts. The Chemed representative went through the charts with CW3 and confirmed that the patients were not appropriate and that "the documentation's not there" and the patients should be discharged. CW6 also confirmed that during his tenure internal audits were conducted by the company.

132. The DOJ Complaint reports that "Chemed and Vitas were also aware that their Medicare billings for crisis care were excessive as compared to other hospices, yet their billings to Medicare did not decrease." DOJ Complaint ¶71. The National Hospice and Palliative Care Organization (NHPCO) releases annual reports regarding hospice operations. Based on their historical data, "Vitas obtains Medicare reimbursement for crisis care far exceeding that of the rest of the hospice industry...Vitas bills Medicare for twice as many crisis care days as all other hospice providers combined." DOJ Complaint ¶72.

133. When comparing the NHPCO reports to Chemed and VITAS' financial reports throughout the Class Period, "Vitas's crisis care billings are almost six times what would be expected if its crisis care figures were in line with the national average." DOJ Complaint ¶¶72-76.

I. Defendants Emphasize VITAS' Revenue Growth and Compliance with Medicare

134. Despite VITAS' improper patient enrollment and billing practices, throughout the Class Period, Defendants repeatedly emphasized VITAS' revenue growth and compliance with Medicare rules and regulations.

135. Quarter after quarter, Chemed's financial statements purported to show consistent and increasing profits for the VITAS segment, with net revenues of $217.6 million in the fourth quarter of 2009, $222.9 million in the first quarter of 2010, $226.6 million in the second quarter of 2010, $234.0 million in the third quarter of 2010, $242 million in the fourth quarter of 2010, $236 million in the first quarter of 2011, $243 million in the second quarter of 2011 and $253 million in the third

quarter of 2011. Defendants repeated and elaborated upon VITAS' positive financial performance in SEC filings, press releases and conference calls with analysts.

136. Defendants attributed VITAS' revenue increases, in part, to "increased ADC [average daily census] and admissions." Throughout the Class Period, Defendants cited what appeared to be legitimate explanations for VITAS' admissions growth, stating, among other things, that VITAS has "placed significant emphasis on increasing admissions," "generated some extremely positive improvements in [its] overall admission trends" and that it was now able to achieve "better responses from [its] admissions areas to get to people very quickly, and appropriately discuss the hospice option with them." Rather than disclose the true reason behind VITAS' increase in hospice admissions growth (*i.e.*, the fact that the Company was improperly admitting patients who were not eligible for hospice care), Defendants attributed the increase in admissions growth to "the expansion of our inpatient units" and "investments in our field personnel, in terms of staffing, training and support."

137. Throughout the Class Period, Defendants also insisted that their billing practices were appropriate and in compliance with Medicare rules and regulations. They repeatedly told investors, "[w]e believe our hospice programs comply with all payor requirements at the time of billing" and "[w]e believe that we are in material compliance with Medicare and Medicaid rules and regulations applicable to hospice providers."

J. Investigations of VITAS Alert Defendants to Abuses at the Company

138. In mid 2005, the OIG for the Department of Health and Human Services began an investigation of VITAS for its alleged failure to appropriately bill Medicare and Medicaid for hospice services. Four years later, in May 2009, the OIG launched another investigation into VITAS and issued a subpoena to the Company, requesting documents, patient records, and policy and procedure manuals concerning hospice services provided for the period January 1, 2003 to the date

of the letter. In February 2010, VITAS received a companion civil investigative demand from the state of Texas Attorney General's Office, seeking related documents.

139. These investigations, which are ongoing, alerted Defendants to the possibility of misconduct at the Company. At a minimum, Defendants were reckless in failing to establish internal controls to prevent such misconduct, which was ongoing long after the initial investigations were initiated.

K. Materially False And Misleading Statements Made During the Class Period

1. February 15, 2010 and February 16, 2010 Statements Regarding 4Q09 and FY09 Results

140. The Class Period begins on February 15, 2010. On that date, Chemed issued a press release announcing its financial results for the fourth quarter and year end 2009, the period ended December 31, 2009. For the quarter, the Company reported revenues of $303.2 million and net income of $17.99 million. For the year, the Company reported revenues of $1.19 billion and net income of $73.78 million. In the VITAS segment, the Company reported net revenues of $217.6 million, net income of $19.4 million, and patient admissions of 13,677 for the quarter. For the year, the Company reported VITAS revenues of $854.3 million and net income of $72.16 million. The press release described the reasons for revenue growth in VITAS, stating, in pertinent part, as follows:

> Net revenue for VITAS was $217.6 million in the fourth quarter of 2009, which is an increase of 5.7% over the prior year period. ***This revenue growth was the result of increased ADC [average daily census] and admissions of 2.7% and Medicare price increases of approximately 3.5%.***
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> Average revenue per patient per day in the quarter, before the effect of the Medicare Cap, was $196.28, which is 3.6% above the prior-year period. Routine home care reimbursement and high acuity care averaged $154.74 and $678.94, respectively, per patient per day in the fourth quarter of 2009. During the quarter, high acuity days-of-care were 7.9% of total days-of-care. This compares to high acuity days of care of 7.8% in the prior-year quarter.

141. The next day, on February 16, 2010, Chemed held a conference call for analysts and investors to discuss the Company's earnings release and operations. Defendants McNamara, Williams and O'Toole participated in the conference call and spoke positively about the Company's businesses and prospects. Defendant McNamara made the following statements regarding VITAS' hospice admissions:

> In the fourth quarter of 2009, our admissions totaled 13,677, an increase of 2.7% over the prior-year quarter. Admissions growth has been challenging in 2009. However, ***through a combination of increased resources and significant effort by our field-based personnel, we have begun to positively impact our admissions trends. These efforts have generated a 2.9% admissions growth in the second half of 2009.*** In the fourth quarter of 2009, VITAS recorded a reduction in revenue due to an estimated Medicare cap limitation of $1.8 million. The amount recorded relates predominantly to one program, which is our largest provider number. Admissions for this provider were strong during the quarter. However, revenue increased at a more rapid pace during the quarter due to a decrease in overall discharges and a mix shift to higher acuity days of care. The full-year gross margin for the program, including the Medicare cap limitation, was approximately 28%.

Defendant O'Toole also discussed the increase in hospice admissions growth at VITAS, stating, in pertinent part, as follows:

> Over the past year ***we have placed significant emphasis on increasing admissions. We have begun to see a return for these efforts, with admissions totaling 13,677 in the quarter, an increase of 2.7%. Our largest market, Florida, increased admissions 4.4% in the quarter, and our second largest state presence, California, expanded admissions 3.5%. We were able to expand admissions in ten of our 16 states, and the District of Columbia***.
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> ***Admissions have increased in three of our four top referral categories. During the fourth quarter home-based admissions increased 1.1%, assisted care living facilities increased 7.8% and hospital-referred admissions increased 6.2%***. Nursing home referrals declined 6.6% in the quarter. We have also increased our investment in the admissions arena. Today we have 298 sales representative 119 admissions coordinators and 305 admission nurses. VITAS has increased our total admissions staffing personnel 9.2% when compared to the fourth quarter of 2008. These investments in the sales and admissions areas resulted in an increase of our total admissions cost of $1.4 million, or 9.6% when compared to the prior-year quarter.

142. Also during the February 16, 2010 call, when an analyst asked about the Company's strategy for growing patient admissions in the VITAS segment, the following exchange occurred:

Eric Gommel – Stifel Nicolaus – Analyst:

> Okay. And then going to – you were talking about revamping your admissions sales and marketing strategy, I'm just curious, when you look at that do you see your strategy more as gaining market share from the existing operators in a market, or is it focusing on getting new patients or maybe growing the benefit on a base of patients that maybe haven't had access to it before, and ways you see as maybe the opportunity to further grow access to the benefits?

Defendant O'Toole:

> Well, I think the answer to the question is we're trying to accomplish both of the areas you talked about. We're trying to maintain our market share in competitive markets. Some markets we have very high market share and we're trying to improve our sales effort, both from the professional individuals we hire, and how we train them and oversight them and the material we provide them, and certainly in certain programs where we have smaller market share, some of the new starts that are developed over the last two, three, four years, we're adding sales people, we're trying to grow our market share and we're accomplishing that. And yes, we are going to nonhistorical referral sources more frequently now, as we've developed opportunities to partner with home health companies, personal care companies, various sources out there that we have worked on over the last year, as we saw the hospital market and the nursing home market give us a little less opportunity and that'[s] working for us. So, again, just improving the overall selling, marketing effort, ***having the better responses from our admissions areas to get to people very quickly, and appropriately discuss the hospice option with them.*** So, again, we're just trying to improve on all fronts and I think we're making some progress in all of those areas.

143. The statements referenced above in ¶¶140-42 were materially false and misleading when made because, at the time they were made, Defendants knew (or were reckless in not knowing), but failed to disclose, that: (a) a significant portion of VITAS' hospice admissions, average daily census, revenues and earnings were the direct result of Defendants' scheme to enroll, and keep enrolled, ineligible patients in hospice and fraudulently bill Medicare for inappropriate hospice services; (b) VITAS' reported average revenue per patient per day was materially inflated as a result of unnecessary continuous home care services provided to patients who did not require such services; (c) the Company failed to maintain adequate internal controls and procedures with respect

to hospice admissions and Medicare billing; (d) the Company's financial results were materially inflated as a result of Defendants' fraudulent scheme to enroll, and keep enrolled, ineligible patients in hospice; and, accordingly; and (e) Defendants lacked a reasonable basis for their positive statements about VITAS and its admissions growth. Moreover, the statements in ¶141 were materially false and misleading when made because VITAS' admissions trends were not merely due to "a combination of increased resources and significant effort by our field-based personnel," but rather, VITAS' Company-wide practice of admitting patients who were ineligible for hospice care because they were not terminally ill. In addition, the statements in ¶142 that VITAS was getting "better responses from our admissions areas to get to people very quickly, and appropriately discuss the hospice option with them" were materially false and misleading when made because VITAS' admissions team was routinely admitting patients that they knew were not eligible for hospice and VITAS' marketing personnel were inappropriately attempting to persuade the patients to use VITAS' services. Finally, any statement that VITAS' efforts to grow sales in established markets included the hiring *and training* of professional individuals, or any statement that the Company's success could be attributable in any way to VITAS' efforts to properly train its employees to comply with Medicare rules and regulations, was misleading because VITAS' efforts to train its employees was completely inadequate. *See* ¶¶68-72.

2. February 26, 2010 Form 10-K for FY 2009

144. On February 26, 2010, Chemed filed its annual report for the year ended December 31, 2009 on Form 10-K ("2009 10-K"), which was signed by Defendants McNamara and Williams and reiterated the Company's financial results. The 2009 10-K described Medicare's billing audits and claims review process, stating, in pertinent part, as follows:

> *Billing Audits/Claims Reviews*. ***The Medicare program and its fiscal intermediaries and other payors periodically conduct pre-payment or post-payment reviews*** and other reviews and audits of health care claims, including hospice claims. There is pressure from state and federal governments and other payors to scrutinize health

> care claims to determine their validity and appropriateness. In order to conduct these reviews, the payor requests documentation from Vitas and then reviews that documentation ***to determine compliance with applicable rules and regulations, including the eligibility of patients to receive hospice benefits,*** the appropriateness of the care provided to those patients and the documentation of that care. During the past several years, Vitas' claims have been subject to review and audit. We make appropriate provisions in our accounting records to reduce our revenue for anticipated denial of payment related to these audits and reviews. ***We believe our hospice programs comply with all payor requirements at the time of billing.*** However, we cannot predict whether future billing reviews or similar audits by payors will result in material denials or reductions in revenue.

145. The 2009 10-K also discussed "Regulatory Matters," stating, in pertinent part, as follows:

> In May 2009, VITAS received an administrative subpoena from the U.S. Department of Justice requesting VITAS deliver to the OIG documents, patient records, and policy and procedure manuals for headquarters and its Texas programs concerning hospice services provided for the period January 1, 2003 to the date of the letter. In August 2009, the OIG selected medical records for 59 past and current patients from a Texas program for review. In February 2010, VITAS received a companion civil investigative demand from the state of Texas Attorney General's Office, seeking related documents. Based on the early stage of the investigation and the limited information we have at this time, we cannot predict the outcome of this investigation. ***We believe that we are in material compliance with Medicare and Medicaid rules and regulations applicable to hospice providers.***

146. The statements referenced above in ¶¶144-45 that VITAS' "hospice programs comply with all payor requirements at the time of billing" and "are in material compliance with Medicare and Medicaid rules and regulations" were materially false and misleading when made because, at the time they were made, Defendants were knowingly (or recklessly), violating Medicare and Medicaid rules and regulations by admitting patients who did not qualify for hospice care, recertifying patients who were not qualified for hospice treatment under Medicare laws and guidelines and improperly billing the government for inappropriate services rendered to hospice patients.

3. April 20, 2010 and April 21, 2010 Statements Regarding 1Q10 Results

147. On April 20, 2010, Chemed issued a press release announcing its financial results for the first quarter of 2010, the period ended March 31, 2010. For the quarter, the Company reported

revenues of $308.8 million and net income of $19.36 million. In the VITAS segment, the Company reported net revenues of $222.9 million, net income of $18.4 million, and patient admissions of 14,844 for the quarter. The press release described the reasons for revenue growth in VITAS, stating, in pertinent part, as follows:

> ***Net revenue for VITAS was $222.9 million in the first quarter of 2010***, which is an increase of 7.0% over the prior year period. ***This revenue growth was the result of increased ADC of 5.1%, driven by an increase in admissions of 4.8%, combined with Medicare price increases of approximately 1.3%.***
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> ***The 4.8% admissions growth is attributed to the opening of six additional inpatient units (IPUs) over the past four quarters as well as a significant increase in staffing focused on referral sources and patient admissions***. New IPUs provide increased visibility to referral sources in the community as well as increased capacity to provide hospice care to more high acuity terminally ill patients.
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> ***Average revenue per patient per day in the quarter***, excluding the impact of Medicare Cap and the 2008 retroactive price adjustment, ***was $199.45***, which is 1.8% above the prior-year period. Routine home care reimbursement and high acuity care averaged $154.95 and $678.17, respectively, per patient per day in the first quarter of 2010. During the quarter, high acuity days of care were 8.5% of total days of care. This compares to high acuity days of care of 8.4% in the prior-year quarter.

148. The next day, on April 21, 2010, Chemed held a conference call for analysts and investors to discuss the Company's earnings release and operations. Defendants McNamara, Williams and O'Toole participated in the conference call and spoke positively about the Company's businesses and prospects. Defendant McNamara made the following statements regarding the growth in VITAS' hospice admissions:

> Admission growth had been challenging in 2009. However, through a combination of strategic expansion of our inpatient units in key markets, and an increase in our field-base personnel, ***we have positively impacted our admissions trends over the last three quarters. These efforts have generated a 2.9% admissions growth in the second half of 2009, and a 4.8% increase in admissions in the first quarter of 2010.***

149. Defendant O'Toole also discussed the increase in hospice admissions growth at VITAS, stating, in pertinent part, as follows:

> Over the past year, we have placed significant emphasis on increasing admissions. I am also pleased to say that ***we are reporting very positive results for these efforts, with admissions increasing 4.8% in the quarter to 14,844. Our largest market, Florida, increased admissions, 6.4% in the quarter, and our second largest state presence, California, expanded admissions 4%. We were able to expand admissions in 11 of our 15 states and the District of Columbia . . . I attribute a significant portion of this growth in admissions to our strategy of expanding our inpatient, high acuity care capacity***. This strategy raises VITAS's visibility with our referral sources and key markets. In addition, increased care to high acuity patients can have a very positive impact on our billing potential under the Medicare Cap formula.
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> ***Admissions have increased in three of our four top referral categories. During the first quarter, home-based admissions increased 6%, assisted care living facilities increased 25%, and hospital referred admissions increased 2.8%.*** Nursing home referrals declined 0.4% in the quarter.

150. During the call, when an analyst from Deutsche Bank asked about "the volume strength" that the Company was experiencing in the VITAS segment, Defendant O'Toole responded, in pertinent part, as follows:

> Yeah, I don't think – we tried to talk about some of the trends over the last several quarters with ***us making enhanced efforts to non-traditional referral sources, and adding our strength at the sales level, as well as making sure we're very responsible on the admission nurse side***. When there is a potential referral, to meet the needs immediately of the patient and their families, to bring them on, if that's their choice. So, those are beginning to take hold. The inpatient unit strategy with opening new beds brings in some very short-stay patients, which helps the admission trend, and also over time gives you presence in the referring hospitals, so it builds your home care program as well.

Defendant McNamara added:

> And I would say, (inaudible) commentary, ***we were very happy with the admission trend. We were happy with the census that we held on to***, and if – there's another comment I would make with regard to labor management, which is so important. That remains very good during the quarter on the cost side. Tim alluded to some costs on the administrative side. Some things that were done intentionally. Some of the administrative costs had come from a program of adding inpatient units and more doctors on staff. All of that is intentional, but something we're watching, but I don't want to leave the subject without saying that we had another quarter of very good labor management, which is essential in the business.

151. The statements referenced above in ¶¶147-50 were materially false and misleading when made for the reasons stated in ¶143. In addition, the statements in ¶147 attributing VITAS' admissions growth to the opening of "additional inpatient units" and "significant increase in staffing" were materially false and misleading when made because Defendants failed to also disclose that VITAS' increase in hospice admissions was due in large part to the Company-wide practice of admitting patients who were ineligible for hospice care because they were not terminally ill. Moreover, Defendants' statements in ¶150 that "we're very responsible on the admission nurse side" were materially false and misleading when made because, according to a number of former VITAS employees who worked at VITAS during the Class Period, the admission nurses routinely admitted patients to hospice, regardless of eligibility.

4. April 30, 2010 1Q10 Form 10-Q

152. On April 30, 2010, the Company filed its quarterly report for the first quarter of 2010 on Form 10-Q and reiterated the financial results reported on April 20, 2010. Additionally, the quarterly report discussed "Legal and Regulatory Matters" and stated, in pertinent part, as follows:

> In May 2009, VITAS received an administrative subpoena from the U.S. Department of Justice requesting VITAS deliver to the OIG documents, patient records, and policy and procedure manuals for headquarters and its Texas programs concerning hospice services provided for the period January 1, 2003 to the date of the letter. In August 2009, the OIG selected medical records for 59 past and current patients from a Texas program for review. In February 2010, VITAS received a companion civil investigative demand from the state of Texas Attorney General's Office, seeking related documents. Based on the early stage of the investigation and the limited information we have at this time, we cannot predict the outcome of this investigation. ***We believe that we are in material compliance with Medicare and Medicaid rules and regulations applicable to hospice providers.***

153. The statements referenced above in ¶152 that VITAS is "in material compliance with Medicare and Medicaid rules and regulations" were materially false and misleading when made because, at the time they were made, Defendants were knowingly (or recklessly), violating Medicare and Medicaid rules and regulations by admitting patients who did not qualify for hospice care, recertifying patients who were not qualified for hospice treatment under Medicare laws and

guidelines and improperly billing the government for inappropriate services rendered to hospice patients.

5. July 28, 2010 and July 29, 2010 Statements Regarding 2Q10 Results

154. On July 28, 2010, Chemed issued a press release announcing its financial results for the second quarter of 2010, the period ended June 30, 2010. For the quarter, the Company reported revenues of $315 million and net income of $18.9 million. In the VITAS segment, the Company reported net revenues of $226.6 million, net income of $18.3 million, and patient admissions of 14,423 for the quarter. The press release described the reasons for revenue growth in VITAS, stating, in pertinent part, as follows:

> ***Net revenue for VITAS was $226.6 million in the second quarter of 2010***, which is an increase of 7.3% over the prior year period. ***This revenue growth was the result of increased ADC of 5.6%, driven by an increase in admissions of 4.2%, combined with Medicare price increases of approximately 1.3%. The remaining growth was driven by geographic mix shift of the patient base***.
>
> The 4.2% admissions growth in the second quarter of 2010 compares favorably to the 0.8% decline in admissions in the prior-year quarter and a 0.7% decline in admissions for full-year 2009.
>
> ***Average revenue per patient per day in the quarter***, excluding the impact of Medicare Cap, ***was $197.89***, which is 1.8% above the prior-year period. Routine home care reimbursement and high acuity care averaged $155.33 and $682.40, respectively, per patient per day in the second quarter of 2010. During the quarter, high acuity days of care were 8.1% of total days of care. This is essentially equal to the prior-year quarter.

155. The next day, on July 29, 2010, Chemed held a conference call for analysts and investors to discuss the Company's earnings release and operations. Defendants McNamara, Williams and O'Toole participated in the conference call and spoke positively about the Company's businesses and prospects. Defendants made the following statements regarding the performance of the Company's VITAS segment:

Defendant McNamara:

In the second quarter of 2010, our hospice business segment generated revenue of $227 million, an increase of 7.3% over the comparable prior year period. VITAS provided an adjusted EBITDA of $33.1 million, an increase of 5.6% compared to the second quarter of 2009. This equated to an adjusted EBITDA margin of 14.6%. ***Our admissions expanded 4.2% in the quarter and have increased 4.5% on a year-to-date basis.*** This compares to a 4% decline in admissions in the first six months of 2009. ***This improvement in admissions trend is attributable to*** several factors. The most significant has been ***the expansion of our inpatient units, or IPUs, over the past year.*** As of June 30, 2010, VITAS has 31 dedicated IPUs with a total daily capacity of 414 beds. This is a 15% increase in IPU locations and 11% increase in patient beds. New IPUs provide increased visibility to the referral sources in the community as well as increased capacity to provide hospice care to our high acuity patients.

* * *

We have also made significant investments in our field personnel, in terms of staffing, training and support. These investments are now providing a noticeable improvement in our overall admissions trends.

* * *

Defendant Williams:

As Kevin noted, net revenue for VITAS was $227 million in the second quarter of 2010, which is an increase of 7.3% over the prior year period. ***This revenue growth was a result of increased ADC of 5.6%, driven by an increase in admissions of 4.2% combined with Medicare price increases of approximately 1.3%. The remaining growth was driven by a geographic mix shift in our patient base.*** The 4.2% admissions growth in the second quarter of 2010 compares favorably to the 0.8% decline in admissions in the prior year quarter and the 0.7% decline in admissions for a full year 2009.

* * *

Defendant O'Toole:

VITAS, as well as the hospice industry, experienced a reduction in admission trends during 2009. ***To counter this trend, we made significant investments in our marketing, sales and admission personnel and developed specific market strategies to maximize VITAS' opportunity in all of our locations. These efforts have begun to provide noticeable improvements in our admission trends.***

In the second quarter of 2010, VITAS admitted 14,423 patients, which is 4.2% higher than the prior year quarter. And for the first six months of 2010, admissions increased at a 4.5% rate. On a year-to-date basis, our largest state, Florida, increased admissions by 7.1%. And our second largest state presence, California, expanded admissions by 1.7%. Our most difficult states in 2009 were Illinois and Texas. The

admissions for both of these states have stabilized. And in the first half of 2010, Illinois' admissions were effectively flat, and Texas declined just 1%. ***This growth in admissions is in part due to our strategy of expanding inpatient capacity.*** This strategy raises VITAS' visibility with our referral sources in key markets. In addition, increased care to high acuity patients has a very positive impact on our billing potential under the Medicare cap formula.

* * *

Admissions have increased in three of our four top referral categories. During the second quarter, home-based admissions increased 8.1%, assisted care living facilities increased 10.7%, and hospital-referred admissions increased 2.4%. Nursing home referrals declined less than 1% in the quarter.

156. The statements referenced above in ¶¶154-55 were materially false and misleading when made for the reasons stated in ¶143.

6. July 30, 2010 2Q10 Form 10-Q

157. On July 30, 2010, the Company filed its quarterly report for the second quarter of 2010 on Form 10-Q and reiterated the financial results reported on July 28, 2010. Additionally, the quarterly report discussed "Legal and Regulatory Matters" and stated, in pertinent part, as follows:

In May 2009, VITAS received an administrative subpoena from the U.S. Department of Justice requesting VITAS deliver to the OIG documents, patient records, and policy and procedure manuals for headquarters and its Texas programs concerning hospice services provided for the period January 1, 2003 to the date of the letter. In August 2009, the OIG selected medical records for 59 past and current patients from a Texas program for review. In February 2010, VITAS received a companion civil investigative demand from the state of Texas Attorney General's Office, seeking related documents. Based on the early stage of the investigation and the limited information we have at this time, we cannot predict the outcome of this investigation. ***We believe that we are in material compliance with Medicare and Medicaid rules and regulations applicable to hospice providers.***

158. The statements referenced above in ¶157 that VITAS is "in material compliance with Medicare and Medicaid rules and regulations" were materially false and misleading when made because, at the time they were made, Defendants were knowingly (or recklessly), violating Medicare and Medicaid rules and regulations by admitting patients who did not qualify for hospice care, recertifying patients who were not qualified for hospice treatment under Medicare laws and

guidelines and improperly billing the government for inappropriate services rendered to hospice patients.

7. October 25, 2010 and October 26, 2010 Statements Regarding 3Q10 Results

159. On October 25, 2010, Chemed issued a press release announcing its financial results for the third quarter of 2010, the period ended September 30, 2010. For the quarter, the Company reported revenues of $320.5 million and net income of $21 million. In the VITAS segment, the Company reported net revenues of $234 million, net income of $19.8 million, and patient admissions of 14,483 for the quarter. The press release described the reasons for revenue growth in VITAS, stating, in pertinent part, as follows:

> ***Net revenue for VITAS was $234.0 million in the third quarter of 2010***, which is an increase of 7.8% over the prior-year period. ***This revenue growth was the result of increased ADC of 6.1%, driven by an increase in admissions of 5.4%, combined with Medicare price increases of approximately 1.3%. The remaining growth was driven by geographic mix shift of the patient base***.
>
> The 5.4% admissions growth in the third quarter of 2010 compares favorably to the 3.1% increase in admissions in the prior-year quarter and a 0.7% decline in admissions for full-year 2009.
>
> ***Average revenue per patient per day in the quarter***, excluding the impact of Medicare Cap, ***was $197.90***, which is 1.6% above the prior-year period. Routine home care reimbursement and high acuity care averaged $155.49 and $689.30, respectively, per patient per day in the third quarter of 2010. During the quarter, high acuity days of care were 7.9% of total days of care. This is essentially equal to the prior-year quarter.

160. The next day, on October 26, 2010, Chemed held a conference call for analysts and investors to discuss the Company's earnings release and operations. Defendants McNamara, Williams and O'Toole participated in the conference call and spoke positively about the Company's businesses and prospects. Defendants made the following statements regarding the performance of the Company's VITAS segment:

Defendant McNamara:

Our admissions expanded 5.4% in the quarter and have increased 4.8% on a year-to-date basis. This compares to a 1.7% decline in admissions in the first nine months of 2009. ***This improvement in admissions trends is attributable to several factors, the most significant has been the expansion of our inpatient units, or IPUs, over the past year***.

* * *

We've also made ***significant investments in our field personnel in terms of staffing, training, and support. These investments are now providing a noticeable improvement in our overall admissions trends***.

* * *

Defendant Williams:

As Kevin noted, the net revenue for VITAS was $234 million in the third quarter of 2010, which is an increase of 7.8% over the prior year period. ***This revenue growth was a result of increased ADC of 6.1%, driven by an increase of admissions of 5.4%, increased discharges of 4.7%, combined with Medicare price increases of approximately 1.3%. The remaining difference was driven by geographic mix shift of the patient base***. Our average revenue per patient per day in the quarter, excluding the impact of Medicare Cap, was $197.90, which is 1.6% above the prior year period.

* * *

Defendant O'Toole:

VITAS is continually monitoring and adjusting its local field efforts in terms of generating awareness of the hospice benefit for Medicare. ***Through the hard work of all of our employees we have generated some extremely positive improvements in our overall admission trends. This has resulted in VITAS admitting 14,483 patients in the quarter, which is 5.4% higher than the prior year***.

During the quarter our largest State, ***Florida, increased admissions 9.3%, and our second largest State presence, California, expanded admissions 4.1%. We were able to expand admissions in 11 of the 15 States plus the District of Columbia, in which VITAS operates***.

* * *

Admissions have increased in three of our four top referral categories. During the third quarter home based admissions increased 8.5%, assisted care living facilities admissions increased 5.6%, and hospital referred admissions increased 5.9%. Nursing home referrals declined 2.4% in the quarter. ***This growth in admissions is in part due to our strategy of expanding inpatient capacity***. This strategy raises VITAS' visibility with our referral sources in key markets. In addition, increased

care to high acuity patients has a positive impact on our billing potential under the Medicare Cap formula.

161. During the call, when an analyst from Barclays asked how much of VITAS' admissions growth was attributed to Chemed's initiatives versus the growth in the hospice industry overall, Defendant O'Toole responded, in pertinent part, as follows:

> Well, ***I'd like to attribute most of the impact from initiatives that we took***, you know, the economy is a minor issue, I don't want to overstate it. So those are issues. We continue to have a lot of resources coming to the table. ***We're getting to the referrals sooner. We're providing great care, and the inpatient unit activity, the continuous care program, all of our marketing, we're – we have big market presence in many of our locations***.
>
> As you know, our strategy is to go into large markets, which gives us continual opportunity to expand. One of the ways we expand is by opening satellite offices, and we've done numerous of those during the year. They're not considered new starts. So, again, ***all those initiatives I expect to continue, and as I say we're optimistic***.

162. The statements referenced above in ¶¶159-61 were materially false and misleading when made for the reasons stated in ¶143.

8. November 3, 2010 3Q10 Form 10-Q

163. On November 3, 2010, the Company filed its quarterly report for the third quarter of 2010 on Form 10-Q and reiterated the financial results reported on October 25, 2010. Additionally, the quarterly report discussed "Legal and Regulatory Matters" and stated, in pertinent part, as follows:

> In May 2009, VITAS received an administrative subpoena from the U.S. Department of Justice requesting VITAS deliver to the OIG documents, patient records, and policy and procedure manuals for headquarters and its Texas programs concerning hospice services provided for the period January 1, 2003 to the date of the letter. In August 2009, the OIG selected medical records for 59 past and current patients from a Texas program for review. In February 2010, VITAS received a companion civil investigative demand ("CID") from the state of Texas Attorney General's Office, seeking related documents. In September 2010, it received a second CID and a second administrative subpoena seeking related documents. Based on the early stage of the investigation and the limited information we have at this time, we cannot predict the outcome of this investigation. ***We believe that we are in material compliance with Medicare and Medicaid rules and regulations applicable to hospice providers.***

164. The statements referenced above in ¶163 that VITAS is "in material compliance with Medicare and Medicaid rules and regulations" were materially false and misleading when made because, at the time they were made, Defendants were knowingly (or recklessly), violating Medicare and Medicaid rules and regulations by admitting patients who did not qualify for hospice care, recertifying patients who were not qualified for hospice treatment under Medicare laws and guidelines and improperly billing the government for inappropriate services rendered to hospice patients.

9. February 15, 2011 and February 16, 2011 Statements Regarding 4Q10 and FY10 Results

165. On February 15, 2011, Chemed issued a press release announcing its financial results for the fourth quarter and year end of 2010, the period ended December 31, 2010. For the quarter, the Company reported revenues of $336 million and net income of $22.6 million. For the year, the Company reported revenues of $1.28 billion and net income of $81.83 million. In the VITAS segment, the Company reported net revenues of $242 million, net income of $23.3 million, and patient admissions of 14,776 for the quarter. For the year in VITAS, the Company reported revenues of $925.81 million and net income of $79.8 million. The press release described the reasons for revenue growth in VITAS, stating, in pertinent part, as follows:

> ***Net revenue for VITAS was $242 million in the fourth quarter of 2010***, which is an increase of 11.4% over the prior-year period. Excluding the impact of Medicare Cap, revenue increased 10.9%. ***This revenue growth was the result of increased ADC of 7.7%, driven by an increase in admissions of 8.0%, combined with Medicare price increases of approximately 2.1%. The remaining growth was driven by geographic mix shift of the patient base***.
>
> ***Average revenue per patient per day in the quarter***, excluding the impact of Medicare Cap, ***was $202.21***, which is 3.0% above the prior-year period. Routine home care reimbursement and high acuity care averaged $159.31 and $701.21, respectively, per patient per day in the fourth quarter of 2010. During the quarter, high acuity days of care were 7.9% of total days of care, essentially equal to the prior-year quarter.

166. The next day, on February 16, 2011, Chemed held a conference call for analysts and investors to discuss the Company's earnings release and operations. Defendants McNamara, Williams and O'Toole participated in the conference call and spoke positively about the Company's businesses and prospects. Defendant McNamara made the following statements regarding the improvement in VITAS' admissions trends:

> In the fourth quarter of 2010 our admissions totaled 14,776, an increase of 8% over the prior-year quarter. This brings our full-year 2010 admissions growth to 5.6%. ***This improvement in admissions trends in 2010 is attributed to several factors. The most significant has been the expansion of our inpatient units, or IPUs, over the past year.*** As of December 31, 2010, VITAS now has 32 dedicated IPUs with a total daily capacity of 427 beds. Over 75% of our inpatient days of care are within these dedicated units. The remaining 25% of our high-acuity inpatient care is provided with short-term contract beds.
>
> * * *
>
> We have also made ***significant investments in our field personnel in terms of staffing, training, and support.*** These investments ***have provided a noticeable improvement in our overall admissions trends***.

Defendant O'Toole also commented on VITAS' admissions, stating, in pertinent part, as follows:

> Thank you, David. As most of you are aware, ***we have put considerable efforts into our marketing and community education programs to increase admissions. Through the hard work of all of our employees, those who are directly responsible for developing referral sources and admitting patients and those providing excellent care, we have generated a total of 58,526 admissions in 2010.*** This is an increase of 5.6% over the prior year. These admissions, coupled with our patient census at the start of the year, resulted in VITAS caring for over 70,000 patients in 2010. I could not be more appreciative of all of the hard work from our employees during 2010, particularly our 200-plus hospice teams that deliver excellent care to the patients and families we serve.
>
> In the fourth quarter of 2010, we admitted 14,776 patients, which is 8% higher than the prior-year quarter. During the quarter, our largest state, ***Florida, increased admissions 10.7%, and our second largest state presence, California, expanded admissions 7.6%. We were able to expand admissions in 11 of the 15 states, plus the District of Columbia, in which VITAS operates.*** Our most difficult states in 2009 had been Illinois and Texas. Both of these states have stabilized and in 2010, Illinois admissions declined 0.4%, and Texas increased 2.2%. These results represent a significant improvement over the prior-year period.
>
> ***Admissions have increased in all four of our largest referral categories. During the fourth quarter, home-based admissions increased 7.4%, assisted care living***

> ***facilities increased 18.9%, hospital-referred admissions increased 7.8%, and nursing home admissions increased 4%. This growth in admissions is in part due to our strategy of expanding inpatient capacity.*** This strategy raises VITAS' visibility with our referral sources in key markets. In addition, increased care to high-acuity patients has a very positive impact on our billing potential under the Medicare Cap formula.

167. During the call, Frank Morgan, an analyst at RBC Capital Markets, asked about any ongoing Medicare billing audits or claims reviews. In response, Defendant O'Toole stated, in pertinent part, as follows:

> They're always continuing, whether they be at the federal level, or various state level reviews, and ***we're doing very well in that regard and have improved, as Dave just mentioned, our internal processes. So we make sure we have all of the key documents in the file for those reviews and upgrading every aspect of our compliance program***.

168. The statements referenced above in ¶¶165-67 were materially false and misleading when made for the reasons stated in ¶143. In addition, the statements referenced in ¶167 that VITAS was "upgrading every aspect of [its] compliance program" and making sure it had "all of the key documents in the file" for Medicare billing audits and claims reviews was materially false and misleading when made because patient eligibility for hospice services at VITAS was based on inaccurate and manipulated documentation. Moreover, VITAS improperly received payments from Medicare for services rendered to ineligible hospice patients.

10. February 28, 2011 Form 10-K for FY 2010

169. On February 28, 2011, Chemed filed its annual report for the year ended December 31, 2010 on Form 10-K ("2010 10-K"), which was signed by Defendants McNamara and Williams and reiterated the Company's financial results. The 2010 10-K described Medicare's billing audits and claims review process, stating, in pertinent part, as follows:

> *Billing Audits/Claims Reviews*. ***The Medicare program and its fiscal intermediaries and other payors periodically conduct pre-payment or post-payment reviews*** and other reviews and audits of health care claims, including hospice claims. There is pressure from state and federal governments and other payors to scrutinize health care claims to determine their validity and appropriateness. In order to conduct these reviews, the payor requests documentation from Vitas and then reviews that

> documentation ***to determine compliance with applicable rules and regulations, including the eligibility of patients to receive hospice benefits***, the appropriateness of the care provided to those patients and the documentation of that care. During the past several years, Vitas' claims have been subject to review and audit. We make appropriate provisions in our accounting records to reduce our revenue for anticipated denial of payment related to these audits and reviews. ***We believe our hospice programs comply with all payor requirements at the time of billing.*** However, we cannot predict whether future billing reviews or similar audits by payors will result in material denials or reductions in revenue.

170. The 2010 10-K also discussed "Regulatory Matters," stating, in pertinent part, as follows:

> In May 2009, VITAS received an administrative subpoena from the U.S. Department of Justice requesting VITAS deliver to the OIG documents, patient records, and policy and procedure manuals for headquarters and its Texas programs concerning hospice services provided for the period January 1, 2003 to the date of the letter. In August 2009, the OIG selected medical records for 59 past and current patients from a Texas program for review. In February 2010, VITAS received a companion civil investigative demand ("CID") from the state of Texas Attorney General's Office, seeking related documents. In September 2010, it received a second CID and a second administrative subpoena seeking related documents. We can neither predict the outcome of this investigation nor estimate our potential liability, if any. ***We believe that we are in compliance with Medicare and Medicaid rules and regulations applicable to hospice providers***.

171. The statements referenced above in ¶¶169-70 that VITAS' "hospice programs comply with all payor requirements at the time of billing" and "are in material compliance with Medicare and Medicaid rules and regulations" were materially false and misleading when made because, at the time they were made, Defendants were knowingly (or recklessly, violating Medicare and Medicaid rules and regulations by admitting patients who did not qualify for hospice care, recertifying patients who were not qualified for hospice treatment under Medicare laws and guidelines and improperly billing the government for inappropriate services rendered to hospice patients.

11. April 25, 2010 and April 26, 2010 Statements Regarding 1Q11 Results

172. On April 25, 2011, Chemed issued a press release announcing its financial results for the first quarter of 2011, the period ended March 31, 2011. For the quarter, the Company reported revenues of $331 million and net income of $18.1 million. In the VITAS segment, the Company

reported net revenues of $236 million, net income of $18.1 million, and patient admissions of 15,798 for the quarter. The press release described the reasons for revenue growth in VITAS, stating, in pertinent part, as follows:

> ***Net revenue for VITAS was $236 million in the first quarter of 2011***, which is an increase of 5.7% over the prior-year period. Both periods include revenue from the reversal of Medicare Cap accruals. Excluding this impact of Medicare Cap, revenue increased 6.1%. ***This revenue growth was the result of increased ADC of 4.8%, driven by an increase in admissions of 6.4%, combined with Medicare price increases of approximately 2.1%.*** This growth was partially offset by geographic and level of acuity mix shift of the patient base.
>
> ***Average revenue per patient per day in the quarter***, excluding the impact of Medicare Cap, ***was $201.82***, which is 1.2% above the prior-year period. Routine home care reimbursement and high acuity care averaged $157.93 and $696.25, respectively, per patient per day in the first quarter of 2011. During the quarter, high acuity days of care were 8.2% of total days of care, 35 basis points lower than the prior-year quarter.

173. The next day, on April 26, 2011, Chemed held a conference call for analysts and investors to discuss the Company's earnings release and operations. Defendants McNamara, Williams and O'Toole participated in the conference call and spoke positively about the Company's businesses and prospects. Defendants made the following statements regarding the performance of the Company's VITAS segment:

> Defendant McNamara:
>
> In the first quarter of 2011, our admissions totaled 15,798, an increase of 6.4% over the prior-year quarter. The ***growth in our admissions in 2010 and 2011 are attributable to several factors. We continue to expand our presence in local communities with new or refurbished inpatient unit***s. This provides VITAS with increased visibility to our referral sources, as well as an increased capacity to provide hospice care to our high acuity patients.
>
> As of March 31, 2011, VITAS has 32 dedicated IPUs with a total daily capacity of 427 beds. This is an increase of 6% over the prior-year quarter. Approximately 73% of our inpatient days of care are within these dedicated units. The remaining 27% of our high acuity inpatient care provided within short-term contract beds. I anticipate this approach in using inpatient units of maximizing our visibility within the healthcare community to be a permanent part of our admissions strategy. We continue to expand our marketing and community liaison personnel in terms of staffing, training, and support. ***These investments in personnel, coupled with our***

inpatient units, have resulted in significant improvement in overall admission strengths.

* * *

Defendant Williams:

Thanks, Kevin. The net revenue for VITAS was $236 million in the first quarter of 2011, which is an increase of 5.7% over the prior-year period. If you exclude the impact of Medicare cap, our revenue increased 6.1%. This ***revenue growth was the result of increased ADC of 4.8%, driven by an increase in admissions of 6.4%, combined with Medicare price increases of approximately 2.1%***. This was partially offset by acuity and geographic mix shift of our patient base.

* * *

Defendant O'Toole:

Thank you, David. As most of you are aware, ***we have put considerable effort into our field-based sales and marketing efforts over the past year.*** We have made significant investments in terms of admission personnel, community liaisons, long-term care liaisons, and admissions coordinators. These investments have been in the form of increased personnel training and educational materials. ***This focus has resulted in VITAS generating a record 15,798 admissions in the quarter, an increase of 6.4% over the first quarter of 2010.*** At this rate, VITAS is on track to provide end-of-life care to more than 76,000 patients in 2011.

During the quarter, our largest state, ***Florida, increased admissions 8.5%, and our second largest state presence, California, expanded admissions 7.9%. We were able to expand admissions in 11 of the 15 states, plus the District of Columbia, in which VITAS operates. Admissions have increased in each of our four largest referral categories. During the first quarter of 2011, home-based admissions increased 5.9%. Assisted care living facilities increased 14%. Hospital referred admissions increased 7.5%. And nursing home admissions increase 0.2%.***

In addition to the significant expansion of our admissions-focused personnel, growth in admissions is also attributed to our focus on expanding inpatient capacity. This strategy raises VITAS's visibility within the healthcare community, resulting in increased admissions. In addition, providing more high acuity care further minimizes the likelihood of reaching billing limitations under the Medicare cap formula.

174. The statements referenced above in ¶¶172-73 were materially false and misleading when made for the reasons stated in ¶143.

12. April 29, 2011 1Q11 Form 10-Q

175. On April 29, 2011, the Company filed its quarterly report for the first quarter of 2011 on Form 10-Q and reiterated the financial results reported on April 25, 2011. Additionally, the quarterly report discussed "Legal and Regulatory Matters" and stated, in pertinent part, as follows:

> In May 2009, VITAS received an administrative subpoena from the U.S. Department of Justice requesting VITAS deliver to the Office of Inspector General for the Department of Health and Human Services ("OIG") documents, patient records, and policy and procedure manuals for headquarters and its Texas programs concerning hospice services provided for the period January 1, 2003 to the date of the letter. In August 2009, the OIG selected medical records for 59 past and current patients from a Texas program for review. In February 2010, VITAS received a companion civil investigative demand from the state of Texas Attorney General's Office, seeking related documents. In September 2010, it received a second CID and a second administrative subpoena seeking related documents. In April 2011, the U.S. Attorney provided the Company with a copy of a qui tam complaint filed under seal in U.S. District Court for the Northern District of Texas. The complaint and all the filings in the action remain under seal. The U.S. Attorney has not decided whether to intervene in the action. We are conferring with the U.S. Attorney regarding the Company's defenses to the complaint's allegations. We can neither predict the outcome of this investigation nor estimate our potential liability, if any. ***We believe that we are in compliance with Medicare and Medicaid rules and regulations applicable to hospice providers.***

176. The statements referenced above in ¶175 that VITAS is "in material compliance with Medicare and Medicaid rules and regulations" were materially false and misleading when made because, at the time they were made, Defendants were knowingly (or recklessly), violating Medicare and Medicaid rules and regulations by admitting patients who did not qualify for hospice care, recertifying patients who were not qualified for hospice treatment under Medicare laws and guidelines and improperly billing the government for inappropriate services rendered to hospice patients.

177. On or about July 18, 2011, the OIG published a report titled "Medicare Hospices That Focus on Nursing Facility Residents" regarding concerns raised about Medicare hospice care for nursing facility residents, including inappropriate enrollment and compensation. Nothing specific to Chemed or VITAS was included in the report.

13. July 26, 2011 and July 27, 2011 Statements Regarding 2Q11 Results

178. On July 26, 2011, Chemed issued a press release announcing its financial results for the second quarter of 2011, the period ended June 30, 2011. For the quarter, the Company reported revenues of $333 million and net income of $20.29 million. In the VITAS segment, the Company reported net revenues of $243 million, net income of $18.6 million, and patient admissions of 15,294 for the quarter. The press release described the reasons for revenue growth in VITAS, stating, in pertinent part, as follows:

> ***Net revenue for VITAS was $243 million in the second quarter of 2011***, which is an increase of 7.3% over the prior-year period. Excluding the impact of Medicare Cap, revenue increased 7.4%. ***This revenue growth was the result of increased ADC of 5.8%, driven by an increase in admissions of 6.0%, combined with Medicare price increases of approximately 2.1%***. This growth was partially offset by geographic and level of acuity mix shift of the patient base.
>
> ***Average revenue per patient per day in the quarter***, excluding the impact of Medicare Cap, ***was $200.99***, which is 1.6% above the prior-year period. Routine home care reimbursement and high acuity care averaged $158.67 and $696.00, respectively, per patient per day in the second quarter of 2011. During the quarter, high acuity days of care were 7.9% of total days of care, 20 basis points lower than the prior-year quarter.

179. The next day, on July 27, 2011, Chemed held a conference call for analysts and investors to discuss the Company's earnings release and operations. Defendants McNamara, Williams and O'Toole participated in the conference call and spoke positively about the Company's businesses and prospects. Defendant McNamara made the following statements regarding VITAS' "success in achieving excellent admissions growth":

> In the second quarter of 2011, our admissions totaled 15,294, an increase of 6.0% over the prior year quarter. ***Our success in achieving excellent admissions growth is attributed to several factors***. We continue to expand our presence in local communities with new or refurbished in-patient units. This provides VITAS with increased visibility to our referral sources as well as increased capacity to provide hospice care to our high acuity patients.

* * *

> We've also continued to expand our marketing and community liaison structure in terms of staffing, training and support. These ***investments in personnel, coupled with our in-patient units have resulted in a significant improvement in over all admissions trends***.

Defendant O'Toole also commented on VITAS' admissions, stating, in pertinent part, as follows:

> . . . As most of you are aware, ***we continue to put significant efforts into our admission focus and initiatives. One of the most important aspects to increased admissions is appropriately focused field-based sales and marketing personnel.*** As of June 30, 2011, we have 305 sales representatives, 143 admissions coordinators, 342 admission nurses, 111 community liaisons and 23 long-term care liaisons. Sales representatives and admissions personnel have expanded 6.8% compared to the second quarter of 2010.
>
> ***This focus has resulted in VITAS generating 15,294 admissions in the quarter, an increase of 6% over the second quarter of 2010.*** At this rate, VITAS is on track to provide end-of-life care to more than 76,000 patients in 2011.
>
> ***During the quarter, our largest state, Florida, increased admissions 8.4% and our second largest state presence, California, expanded admissions 2.7%.*** We were able to expand admissions in 13 of the 16 states plus the District of Columbia in which VITAS operates.
>
> ***Admissions have increased in three of our four largest referral categories. During the second quarter of 2011, home-based admissions increased 7.6%, assisted care living facilities increased 12.5% and hospital referred admissions increased 5.2%.*** Nursing home admissions decreased by 5.2%.

180. During the conference call, Defendants responded to questions about the OIG hospice report that was released in July 2011 and downplayed the issues raised in the report and their applicability to Chemed.

181. For example, Brian Zimmerman, an analyst with Deutsche Bank, posed the following question during the conference call:

> Hi. Thanks and good morning. This is Brian Zimmerman in for Darren. Last week the Office of Inspector General came out with a report focusing on Medicare hospices that focus on nursing facility residents. Do you see the government's interest in this area as a potential risk? And the second part of that question is, we've noticed a decline year-over-year in average daily census in nursing facilities, has that changed from competition, from skilled nursing facilities or are you de-emphasizing growth in that setting?

182. The first response to Mr. Zimmerman's question came from Defendant McNamara, who stated that Chemed had grown less dependent on nursing facilities as they started operating their own in-house hospice facilities.

183. Defendant O'Toole then responded to both questions posed by Mr. Zimmerman, responding first to his question about the decline in year-over-year census in nursing facilities and the impact that has on VITAS:

> Yes, just a couple of things. As Kevin highlights, the trend in the nursing homes census for us have been mirroring the reduction and overall nursing home facility beds in the country. There are more ALF beds being built and that's really -- we are just following the industry. Our percentage of nursing home patients, very similar to what it's been in the past, around 30% and we are very pleased with that and think our future there is very good.

184. Defendant O'Toole then responded to Mr. Zimmerman's first question, concerning the OIG report and the potential risk to VITAS and Chemed of the government's focus on Medicare hospices serving nursing homes:

> Briefly speaking about the OIG report, as Kevin mentioned. They sensed some issues there. I think what we would say is hospices are very, very important service that's provided to nursing home patients and just because someone happens to have their residence in a nursing home should not mean they are not entitled to their hospice benefit.
>
> We feel very strongly about that. They raised some concerns about captives, where some companies have maybe two-thirds or more of their census from nursing home patients that they own the nursing home. That may be something they need to look at.
>
> ***VITAS is independent. We don't have that issue at all. We are very comfortable with where we sit.*** Also keep in mind, hospice is additional services. The OIG report indicates some comments about there's care givers already there. Those care givers are not allowed to do hospice services and hospice provides additional services and keep in mind that because hospice is provided for nursing home patients, those patients can stay in the nursing home and aren't shifted aggressively to a higher acuity facility, aka a hospital, where their cost structure would be much higher.
>
> So there's parts of the OIG report I disagree with. Some of the comments are not new. They've been focused on it for a long time. CMS has already responded to the OIG report and they said they will call the issue to the attention of the auditors and so forth about the self-referrals. And as far as the change in the payment system, the

> OIG highlights that they are already looking at changing the system for a U-shaped curve. They are gathering a lot of data. This is one period they will look at but I will not see any changes there soon.

185. The statements referenced above in ¶¶178-84 were materially false and misleading when made for the reasons stated in ¶143. In addition, because VITAS was improperly enrolling ineligible patients – including nursing home patients – for hospice services, Defendants had no basis for their statements that they "are comfortable with where [they] sit" with regard to the OIG investigation and "don't have that issue at all."

14. August 5, 2011 2Q11 Form 10-Q

186. On August 5, 2011, the Company filed its quarterly report for the second quarter of 2011 on Form 10-Q and reiterated the financial results reported on July 26, 2011. Additionally, the quarterly report discussed "Legal and Regulatory Matters" and stated, in pertinent part, as follows:

> In May 2009, VITAS received an administrative subpoena from the U.S. Department of Justice requesting VITAS deliver to the Office of Inspector General ("OIG") for the Department of Health and Human Services documents, patient records, and policy and procedure manuals for headquarters and its Texas programs concerning hospice services provided for the period January 1, 2003 to the date of the letter. In August 2009, the OIG selected medical records for 59 past and current patients from a Texas program for review. In February 2010, VITAS received a companion civil investigative demand ("CID") from the State of Texas Attorney General's Office, seeking related documents. In September 2010, it received a second CID and a second administrative subpoena seeking related documents. In April 2011, the U.S. Attorney provided the Company with a copy of a qui tam complaint filed under seal in U.S. District Court for the Northern District of Texas. In June 2011, the U.S. Attorney provided the company with a partially unsealed second qui tam complaint filed under seal in the U.S. District Court for the Western District of Texas. In June 2011, the U.S. Attorney also provided the Company with a partially unsealed third qui tam complaint filed under seal in the Northern District of Illinois, Eastern Division. The complaint and all the filings in each of these actions remain under seal. The U.S. Attorney has not decided whether to intervene in any of the actions. We are conferring with the U.S. Attorney regarding the Company's defenses to each complaint's allegations. We can neither predict the outcome of this investigation nor estimate our potential liability, if any. ***We believe that we are in compliance with Medicare and Medicaid rules and regulations applicable to hospice providers.***

187. The statements referenced above in ¶186 that VITAS is "in material compliance with Medicare and Medicaid rules and regulations" were materially false and misleading when made

because, at the time they were made, Defendants were knowingly (or recklessly), violating Medicare and Medicaid rules and regulations by admitting patients who did not qualify for hospice care, recertifying patients who were not qualified for hospice treatment under Medicare laws and guidelines and improperly billing the government for inappropriate services rendered to hospice patients.

15. October 25, 2011 and October 26, 2011 Statements Regarding 3Q11 Results

188. On October 25, 2011, Chemed issued a press release announcing its financial results for the third quarter of 2011, the period ended September 30, 2011. For the quarter, the Company reported revenues of $341 million and net income of $21.89 million. In the VITAS segment, the Company reported net revenues of $253 million, net income of $21 million, and patient admissions of 14,879 for the quarter. The press release described the reasons for revenue growth in VITAS, stating, in pertinent part, as follows:

> ***Net revenue for VITAS was $253 million in the third quarter of 2011***, which is an increase of 8.1% over the prior-year period. Excluding the impact of Medicare Cap, revenue increased 7.9%. ***This revenue growth was the result of increased ADC of 6.2%, driven by an increase in admissions of 2.7%, combined with Medicare price increases of approximately 2.1%***. This growth was partially offset by geographic and level of acuity mix shift of the patient base.
>
> ***Average revenue per patient per day in the quarter***, excluding the impact of Medicare Cap, ***was $201.00***, which is 1.6% above the prior-year period. Routine home care reimbursement and high acuity care averaged $158.83 and $704.73, respectively, per patient per day in the third quarter of 2011. During the quarter, high acuity days of care were 7.7% of total days of care, 22 basis points lower than the prior-year quarter.

189. The next day, on October 26, 2011, Chemed held a conference call for analysts and investors to discuss the Company's earnings release and operations. Defendants McNamara, Williams and O'Toole participated in the conference call and spoke positively about the Company's businesses and prospects. Defendant McNamara made the following statements regarding VITAS' "success in achieving excellent admissions growth":

> In the third quarter of 2011 our admissions totaled 14,879, an increase of 2.7% over the prior year quarter. On a year-to-date basis admissions have increased 5.1%. ***Our success in achieving excellent admissions growth is attributed to several factors. We continue to expand our presence in local communities with new or refurbished inpatient units. This provides VITAS with increased visibility to our referral sources as well as increased capacity to provide hospice care to our high acuity patients.***
>
> * * *
>
> We continue to expand our marketing and community liaison structure in terms of staffing, training and support. The head count for this group has increased 12.4% when compared to the prior year. ***These investments in personnel coupled with our inpatient units have resulted in significant momentum and overall improvement in the aggregate admission trends.***

Defendant O'Toole also commented on VITAS' admissions, stating, in pertinent part, as follows:

> ***We continue to put significant efforts into our marketing and admission initiatives. One of the most important aspects of these initiatives is appropriately focused field based sales and marketing personnel.*** As of September 30, 2011, we have 317 sales representatives, 155 admissions coordinators, 363 admission nurses, 170 community liaisons and 26 long term care liaisons. Staffing in these areas has expanded 12.4% compared to the third quarter of 2010. ***This focus has resulted in VITAS generating 45,971 admissions in the first nine months of 2011, an increase of 5.1% over the prior year period.*** At this rate VITAS will provide end of life care to more than 75,000 patients in 2011.
>
> ***Admissions have increased in all four of our largest referral categories. During the third quarter of 2011, home based admissions increased 2.8%. Assisted care living facilities increased 5.1%. Nursing home admissions increased 1.7%, and hospital referred admissions increased 0.1%.***

190. The statements referenced above in ¶¶188-89 were materially false and misleading when made for the reasons set forth in ¶143.

16. November 4, 2011 3Q11 Form 10-Q

191. On November 4, 2011, the Company filed its quarterly report for the third quarter of 2011 on Form 10-Q and reiterated the financial results reported on October 25, 2011. Additionally, the quarterly report discussed "Legal and Regulatory Matters" and stated, in pertinent part, as follows:

> In May 2009, VITAS received an administrative subpoena from the U.S. Department of Justice requesting VITAS deliver to the Office of Inspector General ("OIG") for

> the Department of Health and Human Services documents, patient records, and policy and procedure manuals for headquarters and its Texas programs concerning hospice services provided for the period January 1, 2003 to the date of the letter. In August 2009, the OIG selected medical records for 59 past and current patients from a Texas program for review. In February 2010, VITAS received a companion civil investigative demand ("CID") from the State of Texas Attorney General's Office, seeking related documents. In September 2010, it received a second CID and a second administrative subpoena seeking related documents. In April 2011, the U.S. Attorney provided the Company with a copy of a qui tam complaint filed under seal in U.S. District Court for the Northern District of Texas. In June 2011, the U.S. Attorney provided the company with a partially unsealed second qui tam complaint filed under seal in the U.S. District Court for the Western District of Texas. In June 2011, the U.S. Attorney also provided the Company with a partially unsealed third qui tam complaint filed under seal in the Northern District of Illinois, Eastern Division. The complaint and all the filings in each of these actions remain under seal. The U.S. Attorney has not decided whether to intervene in any of the actions. We are conferring with the U.S. Attorney regarding the Company's defenses to each complaint's allegations. We can neither predict the outcome of this investigation nor estimate our potential liability or range of potential loss, if any. ***We believe that we are in compliance with Medicare and Medicaid rules and regulations applicable to hospice providers.***

192. The statements referenced above in ¶191 that VITAS is "in material compliance with Medicare and Medicaid rules and regulations" were materially false and misleading when made because, at the time they were made, Defendants were knowingly (or recklessly), violating Medicare and Medicaid rules and regulations by admitting patients who did not qualify for hospice care, recertifying patients who were not qualified for hospice treatment under Medicare laws and guidelines and improperly billing the government for inappropriate services rendered to hospice patients.

193. On November 16, 2011, prior to the close of the market, a *Bloomberg News* article titled "Whistleblower Accuses Chemed Unit of Medicare HMO Conspiracy" disclosed that a former VITAS general manager accused Chemed of defrauding the federal government by conspiring with health insurers to enroll Medicare patients who were not dying. According to the former VITAS general manager, VITAS conspired with two HMOs to admit their unprofitable patients into hospice even though they were not facing imminent death and thus were not eligible for hospice care under

Medicare rules. This benefitted VITAS by increasing its hospice customers and enabled the HMOs "to dump non-profitable patients onto hospice, regardless of their qualifications." The article also discussed a U.S. Department of Justice investigation into fraudulent conduct by VITAS. The article stated, in pertinent part, as follows:

> A former Vitas Healthcare Corp. manager has accused the hospice chain of defrauding the federal government by conspiring with health insurers to enroll Medicare patients who weren't dying.
>
> Vitas, a unit of Cincinnati-based Chemed Corp. (CHE), is the largest U.S. provider of hospice care, which has attracted government scrutiny as its Medicare-covered patients have doubled to 1.1 million over the last decade.
>
> Chemed fell 15 percent, the most since April 2008, to $49.10 at 10:37 a.m. in New York.
>
> The allegations came in a lawsuit unsealed last week in U.S. District Court in Dallas. Vitas spokeswoman Kal Mistry said the company "cannot comment on pending litigation."
>
> In the same court, the Department of Justice is seeking internal Vitas documents in an investigation focused on alleged abuses of federal health-insurance programs. **The government has told the court it suspects Vitas of "an extensive scheme" to defraud Medicare and Medicaid of "hundreds of millions of dollars" by falsifying records and hospice certifications.**
>
> Vitas has "consistently been in compliance with Medicare and Medicaid rules," Mistry said.
>
> The newly unsealed suit was filed by Michael Rehfeldt, a former branch manager for Vitas in San Antonio, who is seeking damages for the government as a whistleblower under the U.S. False Claims Act, which entitles him to part of any recoveries. Such claims are also called qui tam suits.
>
> **"False certifications, fraudulent billing and cost shifting to the United States constitute a widespread, systematic practice endemic to Vitas,"** Rehfeldt's suit alleges.
>
> **Investigation Continuing**
>
> The Justice Department said in a court filing that it is "not intervening at this time" in the whistleblower suit, although "its investigation of the allegations will continue." The Texas Attorney General's office filed an identical notice.
>
> Vitas has been Chemed's main engine of growth, accounting for 74 percent of the company's $341.4 million of revenue in the third quarter, when it reported net

income of $21.9 million. Chemed also operates the Roto-Rooter drain-cleaning and plumbing chain.

Rehfeldt, who left Vitas in 2009, also named as defendants WellMed Medical Management Group and Care Level Management LLC, health-maintenance organizations acquired in March by Minnetonka, Minnesota-based UnitedHealth Group Inc. (UNH)

Vitas conspired with the two HMOs to admit their unprofitable patients into hospice, though they weren't facing imminent death and thus weren't eligible for hospice under Medicare rules, the lawsuit says. It says the arrangement allegedly benefitted Vitas by providing hospice patients, while allowing "the HMO defendants to dump non-profitable patients onto hospice, regardless of their qualifications."

'Strong Message'

WellMed and Care Level spokesmen denied Rehfeldt's allegations. The HMOs said the Justice Department and the Texas Attorney General's office have told the companies that they are not joining in the case against WellMed or Inspiris, the UnitedHealth unit that owns Care Level.

"We believe their decisions are correct and send a strong message regarding the merits of this suit," said David Canniff, chief financial officer of Inspiris.

Rehfeldt told his bosses about the misconduct and they ignored him, according to the lawsuit, which says top Vitas executives knew about the illegal arrangement.

A former Vitas executive in Texas, Keith Becker, teamed up with Justo Cisneros, a former Vitas medical director who also worked for the HMOs, "both large referral sources for Vitas," according to the whistleblower complaint. Cisneros referred, enrolled and recertified patients at Vitas who weren't terminally ill, the suit says.

'Paradigm Shift'

To be eligible for hospice, Medicare requires patients must have six months or less to live, certified by two doctors. Yet a patient can stay on hospice indefinitely, as long as a hospice doctor recertifies their terminal diagnosis every 60 days.

"Cisneros signed, wholesale, hundreds or perhaps thousands of certifications without examining patients or even reviewing their charts," Rehfeldt claims in the suit.

Both Becker and Cisneros now work for Inspiris, which owns a hospice in San Antonio. Becker did not return phone messages.

Cisneros denied conspiring to enroll ineligible patients at Vitas. The company's San Antonio operation got caught in a government "paradigm shift," he said in a telephone interview.

> After encouraging hospices to enroll more patients with diagnoses such as dementia and "general debility," Medicare cracked down on the long stays that resulted from admitting them, according to Cisneros.
>
> "These patients were sick," he said. "Yes, they were on longer, but they were needy."
>
> **'Rules Changed'**
>
> In 2008, 22 percent of Vitas's 560 patients in San Antonio were on hospice for at least 500 days, according to Rehfeldt's suit. The average length of stay for all Medicare hospice patients in 2008 was 83 days.
>
> After a Medicare audit of the Vitas San Antonio office in 2007, the company discharged 295 live patients in 2007 and 2008, compared to a total of 64 live discharges in 2005 and 2006, the suit alleges.
>
> "They changed the rules in the middle of the game," Cisneros said. "There was a lot of confusion."

194. The *Bloomberg News* article, and the newly unsealed *qui tam* complaint revealed to investors for the first time that the scope of the government investigation, and the claims raised in the *qui tam* suit, were not limited to a specific VITAS facility and were not discontinued practices. As alleged in the newly unsealed *qui tam* complaint, the wrongdoing was part of a widespread, systematic pattern and practice of knowingly submitting or causing to be submitted false claims to the United States through fraudulent certification and recertification of hospice patients and fraudulent billing of the United States through Medicare or Medicaid. As stated in the *Bloomberg News* article, the government's investigation into VITAS' "extensive scheme" was proceeding separately from the *qui tam* action.

195. In response to the announcements set forth in ¶193, shares of the Company's stock fell $6.87 per share, or 11%, to close at $50.65 per share on November 16, 2011, on extremely heavy trading volume. Chemed securities, however, remained artificially inflated as a result of materially false and misleading statements and omissions made by Defendants during the Class Period.

17. February 27, 2012 Form 10-K for FY2011

196. On February 27, 2012, Chemed filed its annual report for the year ended December 31, 2011 on Form 10-K ("2011 10-K"), which was signed by Defendants McNamara and Williams and reported the Company's financial results for fiscal year 2011. The 2011 10-K described Medicare's billing audits and claims review process, stating, in pertinent part, as follows:

> Billing Audits/Claims Reviews. The Medicare program and its fiscal intermediaries and other payors periodically conduct pre-payment or post-payment reviews and other reviews and audits of health care claims, including hospice claims. There is pressure from state and federal governments and other payors to scrutinize health care claims to determine their validity and appropriateness. In order to conduct these reviews, the payor requests documentation from Vitas and then reviews that documentation to determine compliance with applicable rules and regulations, including the eligibility of patients to receive hospice benefits, the appropriateness of the care provided to those patients and the documentation of that care. Vitas' claims have been subject to review and audit. We make appropriate provisions in our accounting records to reduce our revenue for anticipated denial of payment related to these audits and reviews. ***We believe our hospice programs comply with all payor requirements at the time of billing.*** However, we cannot predict whether future billing reviews or similar audits by payors will result in material denials or reductions in revenue.

197. The 2011 10-K also discussed "Regulatory Matters," stating, in pertinent part, as follows:

> In May 2009, Vitas received an administrative subpoena from the U.S. Department of Justice requesting Vitas deliver to the OIG documents, patient records, and policy and procedure manuals for headquarters and its Texas programs concerning hospice services provided for the period January 1, 2003 to the date of the letter. In August 2009, the OIG selected medical records for 59 past and current patients from a Texas program for review. In February 2010, VITAS received a companion civil investigative demand ("CID") from the State of Texas Attorney General's Office, seeking related documents. In September 2010, it received a second CID and a second administrative subpoena seeking related documents. In April 2011, the U.S. Attorney provided the Company with a copy of a qui tam complaint filed under seal in U.S. District Court for the Northern District of Texas. The Court unsealed this complaint in November 2011. The U.S. Attorney and the Attorney General for the State of Texas filed a notice in November 2011 that they had decided not to intervene at that time in the case. They continue to investigate its allegations. It was brought by Michael Rehfeldt, a former VITAS San Antonio program general manager, against VITAS, the program's former Regional Vice President Keith Becker, its former Medical Director Justo Cisneros, and their current employers: WellMed Medical Management, Care Level Management LLC, and Inspiris Inc. It alleges admission and recertification of inappropriate patients, backdating revocations, and

> conspiring with HMO defendants to admit inappropriate patients to hospice. In June 2011, the U.S. Attorney provided the Company with a partially unsealed second qui tam complaint filed under seal in the U.S. District Court for the Western District of Texas. In June 2011, the U.S. Attorney also provided the Company with a partially unsealed third qui tam complaint filed under seal in the Northern District of Illinois, Eastern Division. We are conferring with the U.S. Attorney regarding the Company's defenses to each complaint's allegations. We can neither predict the outcome of this investigation nor estimate our potential liability or range of potential loss, if any. ***We believe that we are in compliance with Medicare and Medicaid rules and regulations applicable to hospice providers.***

198. The statements referenced above in ¶¶196-97 that VITAS' "hospice programs comply with all payor requirements at the time of billing" and "are in material compliance with Medicare and Medicaid rules and regulations" were materially false and misleading when made because, at the time they were made, Defendants were knowingly (or recklessly), violating Medicare and Medicaid rules and regulations by admitting patients who did not qualify for hospice care, recertifying patients who were not qualified for hospice treatment under Medicare laws and guidelines, and improperly billing the government for inappropriate services rendered to hospice patients.

18. April 30, 2012 1Q12 Form 10-Q

199. On April 30, 2012, the Company filed its quarterly report for the first quarter of 2012 filed with the SEC on Form 10-Q, which discussed "Legal and Regulatory Matters" and stated, in pertinent part, as follows:

> In May 2009, VITAS received an administrative subpoena from the U.S. Department of Justice requesting VITAS deliver to the OIG documents, patient records, and policy and procedure manuals for headquarters and its Texas programs concerning hospice services provided for the period January 1, 2003 to the date of the letter. In August 2009, the OIG selected medical records for 59 past and current patients from a Texas program for review. In February 2010, VITAS received a companion civil investigative demand ("CID") from the State of Texas Attorney General's Office, seeking related documents. In September 2010, it received a second CID and a second administrative subpoena seeking related documents. In April 2011, the U.S. Attorney provided the Company with a copy of qui tam complaint filed under seal in the U.S. District Court for the Northern District of Texas. The Court unsealed this complaint in November 2011. The U.S. Attorney and the Attorney General for the State of Texas filed a notice in November 2011 that they had decided not to intervene at that time in the case. They continue to investigate its allegations. It was brought by Michael Rehfelt, a former Vitas San Antonio program general manager, against Vitas, the program's former Regional Vice President Keith Becker, its former

> Medical Director Justos Cisneros, and their current employers: Wellmed Medical Management, Care Level Management LLC, and Inspiris Inc. Plaintiff dismissed his case against their current employers in March of 2012. The case alleges admission and recertification of inappropriate patients, backdating revocations, and conspiring to admit inappropriate patients to hospice. In June 2011, the U.S. Attorney provided the Company with a partially unsealed second qui tam complaint filed under seal in the U.S. District court for the Western District of Texas. In June 2011, the U.S. Attorney also provided the Company with a partially unsealed third qui tam complaint filed under seal in the Northern District of Illinois, Eastern Division. We are conferring with the U.S. Attorney regarding the Company's defenses to each complaint's allegations. We can neither predict the outcome of this investigation nor estimate our potential liability, if any. ***We believe that we are in compliance with Medicare and Medicaid rules and regulations applicable to hospice providers.***

200. The statement referenced above in ¶199 that VITAS is "in compliance with Medicare and Medicaid rules and regulations" was materially false and misleading when made because, at the time they were made, Defendants were knowingly (or recklessly), violating Medicare and Medicaid rules and regulations by admitting patients who did not qualify for hospice care, recertifying patients who were not qualified for hospice treatment under Medicare laws and guidelines, and improperly billing the government for inappropriate services rendered to hospice patients.

19. July 26, 2012 Statements Regarding 2Q12 Results

201. On July 26, 2012, Chemed held a conference call for analysts and investors to discuss the Company's earnings release and operations for the second quarter of 2012. Defendants McNamara, Williams and O'Toole participated on the conference call and spoke positively about the Company's business and prospects. Defendant McNamara made the following statements regarding VITAS' admissions programs and systems:

> On the litigation front, we've had no significant developments on preexisting claims. However, in June 2012, we received an administrative subpoena from the office of the Inspector General of the US Department of Health and Human Services, focusing on our southern California hospice program's Medicare claims and seeking documents from January 2007. The OIG has requested information related to procedures and policies surrounding admission, recertification, and documentation of long-stay patients. We also received a subpoena from the state of Florida in July of 2012 that seeks documents concerning similar issues over the same time period. We are unable to estimate the timing or outcome of these investigations or our potential liability, if any, with respect to these matters. ***VITAS takes great pride in its systems, admissions programs, and patient documentation policies. This is the***

> ***foundation for supporting our Medicare and Medicaid billings. We have invested significant resources in creating and maintaining this infrastructure that maintains detailed, contemporaneous documentation for every patient. We believe this is the most appropriate way to ensure all our patients receive appropriate care and our Medicare and Medicaid billings are appropriately supported.***

202. The statements referenced above in ¶201 were materially false and misleading when made because, at the time they were made, Defendants were knowingly (or recklessly), violating Medicare and Medicaid rules and regulations by admitting patients who did not qualify for hospice care, recertifying patients who were not qualified for hospice treatment under Medicare laws and guidelines, and improperly billing the government for inappropriate services rendered to hospice patients.

203. On August 2, 2012, the Company filed its Form 10-Q for 2Q12. In the 2Q12 Form 10-Q, the Company described an additional federal investigation, this time into VITAS' Southern California programs for a period of time that included the Class Period, regarding patient eligibility for hospice care:

> In June 2012, VITAS received an administrative subpoena from the Office of the Inspector General ("OIG") of the U.S. Department of Health and Human Services in connection with an investigation of possible improper claims submitted to the Medicare and Medicaid Programs. It seeks production to the OIG of various categories of documents concerning the provision of hospice services, for headquarters and its Southern California programs, for the period January 1, 2007 through the date of the subpoena. The categories of documents include policy, procedure and training manuals; documents concerning patient eligibility for hospice care, including referrals, admissions, certification, revocations and census information; documents concerning claims submitted to government programs; certain information concerning employees and their compensation; and documents concerning VITAS' financial performance. We are conferring with the U.S. Attorney's Office for the Central District of California regarding the document requests. We cannot predict the timing or outcome of this investigation, or estimate our potential liability, if any.

204. The statements referenced above in ¶203 were materially false and misleading when made because, at the time they were made, Defendants were knowingly (or recklessly), violating Medicare and Medicaid rules and regulations by admitting patients who did not qualify for hospice care, recertifying patients who were not qualified for hospice treatment under Medicare laws and

guidelines, and improperly billing the government for inappropriate services rendered to hospice patients.

205. The OIG's investigation into VITAS' operations in California was preceded by the filing of a *qui tam* complaint on January 27, 2012, by Dr. Charles Gonzales, who was employed by VITAS Los Angeles from 2004 until May, 2011. During Dr. Gonzales' tenure with VITAS, he alleged that the Company submitted "thousands" of false certifications of hospice eligibility to Medicare for patients in Los Angeles. While employed by VITAS, Dr. Gonzales was subjected to "constant and strong pressure" from management to certify and/or recertify patients as eligible for hospice care who were not eligible, and cited 34 separate, specific cases where patients were improperly certified or recertified as eligible for hospice care under Medicare's rules and regulations. The average hospice stay for the 34 patients listed in his complaint was two years, seven months. His complaint, initially filed in the Central District of California, was transferred to the Western District of Missouri on April 5, 2013 and unsealed on April 6, 2013. On May 2, 2013, the DOJ filed a notice of intervention in Dr. Gonzales' case.

206. On November 2, 2012, the Company issued its Form 10-Q for 3Q12. In the 3Q12 Form 10-Q, the Company announced its receipt of a subpoenas from the Florida Attorney General's office, the unsealing of two additional *qui tam* complaints, and details surrounding its receipt of additional subpoenas from the OIG:

> In July 2012, VITAS received an investigative subpoena from the Florida Attorney General seeking documents previously produced in the course of prior government investigations as well as, for the period January 1, 2007 through the date of production, billing records and procedures; information concerning business results, plans, and strategies; documents concerning patient eligibility for hospice care; and certain information concerning employees and their compensation. We are conferring with the Attorney General regarding those document requests.
>
> In June 2011, the U.S. Attorney provided the Company with a partially unsealed qui tam complaint filed under seal in the U.S. District Court for the Western District of Texas, *United States, et al. ex rel. Urick v. Vitas HME Solutions, Inc. et al*., 5:08-cv-0663. The U.S. Attorney filed a notice in May 2012 stating that it had decided not to

intervene in the case at that time but indicating that it continues to investigate the allegations. In June 2012, the complaint was unsealed. The complaint asserts violations of the federal False Claims Act and the Texas Medicaid Fraud Prevention Act based on allegations of a conspiracy to submit to Medicare and Medicaid false claims involving hospice services for ineligible patients, unnecessary medical supplies, failing to satisfy certain prerequisites for payment, and altering patient records, including backdating patient revocations. The suit was brought by Barbara Urick, a registered nurse in VITAS's San Antonio program, against VITAS, certain of its affiliates, and several former VITAS employees, including physicians Justo Cisneros and Antonio Cavasos and nurses Sally Schwenk, Diane Anest, and Edith Reed. In September 2012, the plaintiff dismissed all claims against the individual defendants. The complaint has yet to be served on any of the VITAS entities.

Also in June 2011, the U.S. Attorney provided the Company with a partially unsealed qui tam complaint filed under seal in the U.S. District Court for the Northern District of Illinois, *United States, et al. ex rel. Spottiswood v. Chemed Corp.*, 1:07-cv-4566. In April 2012, the complaint was unsealed. The U.S. Attorney and Attorney General for the State of Illinois filed notices in April and May 2012, respectively, stating that they had decided not to intervene in the case at that time but indicating that they continue to investigate the allegations. The complaint asserts violations of the federal False Claims Act and the Illinois Whistleblower Reward and Protection Act based on allegations that VITAS fraudulently billed Medicare and Medicaid for providing unwarranted continuous care services. The suit was brought by Laura Spottiswood, a former part-time pool registered nurse at VITAS, against Chemed, VITAS, and a VITAS affiliate. The complaint has yet to be served.

In June 2012, VITAS received an administrative subpoena from OIG in connection with an investigation of possible improper claims submitted to the Medicare and Medicaid programs. It seeks production of various categories of documents concerning the provision of hospice services, for headquarters and its Southern California programs, for the period January 1, 2007 through the date of the subpoena. The categories of documents include policy, procedure and training manuals; documents concerning patient eligibility for hospice care, including referrals, admissions, certifications, revocations and census information; documents concerning claims submitted to government programs; certain information concerning employees and their compensation; and documents concerning VITAS's financial performance.

In August 2012, the OIG also subpoenaed medical records for 268 patients from three Southern California programs. We are conferring with the U.S. Attorney's Office for the Central District of California regarding those document requests.

207. The statements referenced above in ¶206 were materially false and misleading when made because, at the time they were made, Defendants were knowingly (or recklessly), violating Medicare and Medicaid rules and regulations by admitting patients who did not qualify for hospice care, recertifying patients who were not qualified for hospice treatment under Medicare laws and

guidelines, and improperly billing the government for inappropriate services rendered to hospice patients.

20. February 27, 2013 Form 10-K for FY2012

208. On February 27, 2013, Chemed filed its annual report for the year ended December 31, 2012 on Form 10-K ("2012 10-K"), which was signed by Defendants McNamara and Williams and reported the Company's financial results for fiscal year 2012. The 2012 10-K described Medicare's billing audits and claims review process, stating, in pertinent part, as follows:

> Billing Audits/Claims Reviews. ***The Medicare program and its fiscal intermediaries and other payors periodically conduct pre-payment or post-payment reviews and other reviews and audits of health care claims, including hospice claims***. There is pressure from state and federal governments and other payors to scrutinize health care claims to determine their validity and appropriateness. In order to conduct these reviews, the payor requests documentation from Vitas and then reviews that documentation to determine compliance with applicable rules and regulations, including the eligibility of patients to receive hospice benefits, the appropriateness of the care provided to those patients and the documentation of that care. Vitas' claims have been subject to review and audit. We make appropriate provisions in our accounting records to reduce our revenue for anticipated denial of payment related to these audits and reviews. ***We believe our hospice programs comply with all payor requirements at the time of billing***. However, we cannot predict whether future billing reviews or similar audits by payors will result in material denials or reductions in revenue.

209. The statements referenced above in ¶208 that VITAS' "hospice programs comply with all payor requirements at the time of billing" were materially false and misleading when made because, at the time they were made, Defendants were knowingly (or recklessly), violating Medicare and Medicaid rules and regulations by admitting patients who did not qualify for hospice care, recertifying patients who were not qualified for hospice treatment under Medicare laws and guidelines, and improperly billing the government for inappropriate services rendered to hospice patients.

21. April 26, 2013 1Q13 Form 10-Q

210. On April 26, 2013, the Company filed its quarterly report for the first quarter of 2013 on Form 10-Q. On February 27, 2013, in its 2012 Form 10-K, the Company announced that it received additional subpoenas from the OIG seeking medical records of VITAS patients. The Form 10-Q also stated, in pertinent part, as follows:

> As of March 31, 2013, VITAS has approximately $1.1 million in unbilled revenue included in accounts receivable (December 31, 2012 - $457,000). The unbilled revenue at VITAS relates to hospice programs currently undergoing various patient file reviews. Surveyors working on behalf of the U.S. Federal government review certain patient files for compliance with Medicare regulations. During the time the patient file is under review, we are unable to bill for care provided to those patients. We make appropriate provisions to reduce our accounts receivable balance for any governmental or other payer reviews resulting in denials of patient service revenue. ***We believe our hospice programs comply with all payer requirements at the time of billing.*** However, we cannot predict whether future billing reviews or similar audits by payers will result in material denials or reductions in revenue.

211. The statements referenced above in ¶210 that VITAS' "hospice programs comply with all payor requirements at the time of billing" were materially false and misleading when made because, at the time they were made, Defendants were knowingly (or recklessly, violating Medicare and Medicaid rules and regulations by admitting patients who did not qualify for hospice care, recertifying patients who were not qualified for hospice treatment under Medicare laws and guidelines, and improperly billing the government for inappropriate services rendered to hospice patients.

212. In the 1Q13 Form 10-Q, the Company reported the voluntary dismissal of the *Rehfeldt* action. The Company also reported that the Company had been served with the *qui tam* complaints filed in the Western District of Texas and the Northern District of Illinois.

213. The *Rehfeldt* action was voluntarily dismissed by Rehfeldt for procedural reasons. In an article entitled "Whistle-blower drops suit against hospice company" published by Patrick Danner

on April 16, 2013 on the "MY San Antonio" homepage,[4] Rehfeldt, through his attorney, stated: "We stand by every allegation in that complaint, and we look forward to those allegations coming to light." As the article explains, "[u]nder provisions of the federal False Claims Act, a whistle-blower is barred from bringing a claim if the same allegations already have been made in another lawsuit." Because the *Urick* complaint, referenced in ¶198, had been filed before Rehfeldt's complaint, alleging substantially the same fraudulent conduct by VITAS, Rehfeldt's complaint had to be dismissed.

214. On May 2, 2013, the DOJ filed a Complaint against Chemed and VITAS alleging that Chemed and VITAS had engaged in a widespread and pervasive scheme to inappropriately admit patients into hospice care and that Chemed and VITAS placed patients into continuous care who did not qualify, that this plan worked, and that Chemed and VITAS fraudulently billed Medicare for these inappropriate admissions. The Company discussed the filing of the DOJ Complaint in a Form 8-K filed on May 3, 2013:

> On May 2, 2013, the government filed a False Claims Act complaint against the Company and certain of its hospice-related subsidiaries in the Western District of Missouri, captioned as United States of America v. VITAS Hospice Services, LLC, et al., Case #4:13-cv-00449-BCW. The complaint alleges that, since at least 2002, Vitas, and since 2004, the Company, submitted or caused the submission of false claims to the Medicare program by (a) billing Medicare for crisis care services when the patients were not eligible, the services were not provided, or the medical care was inappropriate, and (b) admitting patients who were not eligible for the Medicare hospice benefit because they did not have a life expectancy of six months or less if their illnesses ran their normal course. The complaint seeks treble damages, statutory penalties, and the costs of the action, plus interest.

215. In response to the announcements set forth in ¶214 about the DOJ Complaint, shares of the Company's stock fell $13.79 per share, or 16.86%, to close at $68.00 per share on May 3, 2013, on extremely heavy trading volume.

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[4] http://www.mysanantonio.com/business/article/Whistle-blower-drops-suit-against-hospice-company-4442855.php

L. Additional Scienter Allegations

216. During the Class Period, Defendants were motivated to keep Chemed's stock price artificially inflated in order to line their own pockets. Chemed had a program that specifically incentivized the Individual Defendants to attain and sustain a target share price and rewarded them handsomely for meeting those stock price targets. This plan, called the Executive Long-Term Incentive Plan ("LTIP") set stock price benchmarks for the Individual Defendants during the Class Period. If the stock price benchmark was achieved during 30 trading days out of any 60 trading day period between May 2009 and February 28, 2012, the Individual Defendants would be given a stock award from a pre-determined pool of shares. For each benchmark attained, the Individual Defendants would be rewarded as detailed below:

	May 2009 Price Targets for the three years ending February 28, 2012[5]		
Price target	$54.00	$58.00	$62.00
Number of shares in the pool	22,500	33,750	33,750
Shares awarded:			
From the pool	22,500	33,750	33,750
Discretionary shares	5,400	7,350	7,350
Total shares Awarded	**27,900**	**41,100**	**41,100**

217. During the Class Period, the Individual Defendants made false and misleading statements in order to boost Chemed's share price and keep it elevated so they could collect on the LTIP. In fact, Chemed's stock price exceeded the targets listed above, and the Individual Defendants were awarded LTIP benefits in April 2010, December 2010, January 2011 and February

[5] 2012 Form 10-K at 15.

2011.[6] In total, the Individual Defendants reaped benefits of $3,693,764 due to the artificial inflation of Chemed's stock.

LTIP Benefits Awarded to the Individual Defendants During the Class Period

Name	LTIP Benefit Grant Date	Number of Shares of Stock	Closing Market Price On Grant Date ($/Share)	Grant Date Fair Value of Award ($)[7]
McNamara	4/16/2010[8]	5,000	56.40	283,050
	12/9/2010[3]	7,000	62.57	439,670
	1/14/2011[9]	7,000	63.33	441,980
	2/18/2011[10]	8700	65.32	566,979
TOTAL				**$1,731,679**
Williams	4/16/2010[3]	2,550	56.40	144,356
	12/9/2010[3]	3,660	62.57	226,116
	1/14/2011[4]	3,600	63.33	227,304
	2/18/2011[11]	4,600	65.32	299,782
TOTAL				**$897,558**

[6] The awards issued on 4/2010, 12/2010 and 1/2011 were "fully vested Capital Stock"(*see* 2011 Proxy at 15). The 2/2011 LTIP award was a "time-based LTIP award of 42,000 shares of restricted stock" given to certain key employees including the Individual Defendants. *See* 2012 Form 10-K at 16.

[7] Amounts represent the aggregate grant date fair value of the awards determined in accordance with FASB's stock based compensation rules. *See* Note 4 to the Consolidated Financial Statements included as Exhibit 13 to the Company's 2010 and 2011 Annual Report on Form 10-K for a description of the assumptions used in determining the grant date fair value. *See* 2011 and 2012 Proxy at 21 respectively.

[8] 2011 Proxy at 15, 21.

[9] 2012 Proxy at 12, 2011 Proxy at 15.

[10] 2012 Proxy at 12, McNamara Form 4 for the period ending 2/18/2011, footnote 2. Unlike the "fully vested Capital Stock"issued in 4/2010, 12/2010 and 1/2011 (*see* 2011 Proxy at 15), this LTIP award is restricted stock vesting in full on 2/18/2015.

[11] 2012 Proxy at 12, Williams Form 4 for the period ending 2/18/11, footnote 2. Unlike the "fully vested Capital Stock"issued in 4/2010, 12/2010 and 1/2011 (*see* 2011 Proxy at 15), this LTIP award is restricted stock vesting in full on 2/18/2015.

Name	LTIP Benefit Grant Date	Number of Shares of Stock	Closing Market Price On Grant Date ($/Share)	Grant Date Fair Value of Award ($)[7]
O'Toole	4/16/2010[3]	3,500	56.40	198,135
	12/9/2010[3]	5,000	62.57	314,050
	1/14/2011[4]	4,000	63.33	252,560
	2/18/2011[12]	4,600	65.32	299,782
TOTAL				**$1,064,527**
Defendants TOTAL LTIP Benefit During the Class Period				**$3,693,764**

218. When information concerning Chemed's fraud was revealed to the market on November 16, 2011, the stock price dropped from a Class Period high of $72.25 to $50.65. Notably, when the market partially corrected Chemed's artificial inflation, it brought Chemed's stock price down below even the initial stock price benchmark of $54.00. Without the Individual Defendants' deception, they would not have collected on the LTIP at all. Notably, Defendants did not meet any of their LTIP goals in 2008 and the Company has announced that it does not expect to meet them in 2012.

219. Defendants' scienter is further evidenced by their insider trading, as set forth in the chart below:

[12] 2012 Proxy at 12, O'Toole Form 4, footnote 2 for the period ending 2/18/11. Unlike the "fully vested Capital Stock"issued in 4/2010, 12/2010 and 1/2011 (*see* 2011 Proxy at 15), this LTIP award is restricted stock vesting in full on 2/18/2015.

Chemed Corp.
(CHE)
Insider Sales: 2/15/10 - 5/2/13

Filer Name	Title	Date	Shares	Price	Proceeds
McNamara	Chief Executive				
(Kevin J)	Officer	27-Apr-2010	15,000	$54.76	$821,400
		28-Oct-2010	10,000	$59.13	$591,300
		04-May-2011	5,000	$69.44	$347,200
		04-Aug-2011	10,000	$56.64	$566,400
		08-Nov-2011	5,000	$58.98	$294,900
		17-Feb-2012	8,000	$62.75	$502,000
		22-Feb-2012	4,000	$62.30	$249,200
		06-Aug-2012	10,000	$61.56	$615,600
		21-Aug-2012	6,000	$66.38	$398,280
		11-Sep-2012	6,000	$69.03	$414,180
		07-Nov-2012	7,000	$68.08	$476,560
		20-Nov-2012	6,000	$66.54	$399,240
		18-Dec-2012	5,000	$69.09	$345,450
		22-Feb-2013	4,000	$78.26	$313,040
		22-Apr-2013	12,000	$77.61	$931,320
			113,000		$7,266,070
O'Toole	Officer				
(Timothy S)		25-Mar-2010	108	$55.20	$5,962
		25-Mar-2010	669	$55.24	$36,956
		25-Mar-2010	723	$55.22	$39,924
		25-Mar-2010	2,000	$55.16	$110,320
		05-May-2010	5,000	$54.09	$270,450
		11-Nov-2010	4,000	$62.32	$249,280
		12-Jan-2011	6,000	$63.31	$379,860
		08-Mar-2011	3,000	$66.72	$200,160
		11-May-2011	8,000	$70.91	$567,280
		29-Feb-2012	3,700	$62.20	$230,140
		24-Sep-2012	6,000	$71.51	$429,060
		23-Apr-2013	12,000	$78.44	$941,280
			51,200		$3,460,671
Williams	Chief Financial				
David Patrick	Officer	30-Apr-2010	3,000	$55.77	$167,310
		09-Dec-2010	7,000	$62.64	$438,480
		22-Feb-2011	15,000	$65.33	$979,950
		08-Aug-2012	5,000	$62.45	$312,250
		11-Sep-2012	5,000	$69.17	$345,850
		09-Nov-2012	10,000	$66.66	$666,600
		28-Feb-2013	10,000	$76.77	$767,700
			55,000		$3,678,140
		Totals:	**219,200**		**$14,404,881**

220. In addition, while Defendant O'Toole exercised 20,000 stock options for the 39 month period before the Class Period and did not exercise any stock options after the Class Period, he exercised a total of 128,750 stock options during the Class Period.[13] Defendant Williams exercised 518,750 stock options during the Class Period[14] and 70,000[15] in the 39 month time frame before the Class Period but has not exercised any stock options since the end of the Class Period. Defendant McNamara exercised 290,000[16] stock options during the Class Period and 126,400[17] in the 39 month time frame before the Class Period and did not exercise any stock options since the end of the Class Period.

221. In addition, as alleged herein, Defendants acted with scienter in that Defendants knew, or were reckless in not knowing, that the public documents and statements issued or disseminated in the name of the Company were materially false and misleading; knew that such statements or documents would be issued or disseminated to the investing public; and substantially participated or acquiesced in the issuance or dissemination of such statements or documents as primary violations of the federal securities laws. As set forth elsewhere herein in detail, Defendants, by virtue of their receipt of information reflecting the true facts regarding Chemed, their control over, and/or receipt and/or modification of Chemed's allegedly materially misleading misstatements and/or their associations with the Company, which made them privy to confidential proprietary information concerning Chemed, participated in the fraudulent scheme alleged herein.

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13 *See* O'Toole Form 4s for 2/27/07, 2/24/10, 6/4/10, 5/5/11, 11/9/11, 8/8/12, 12/19/12, 3/1/13 and 4/24/13.

14 *See* Williams Form 4s for 12/9/10, 2/22/11, 9/12/12, 2/22/13 and 4/26/13.

15 *See* Williams Form 4s for 11/11/08 and 8/11/09 (pre-class period).

16 *See* McNamara Form 4s for 4/26/10, 10/29/10, 5/3/11, 11/9/11, 2/16/12, 8/7/12, 8/22/12, 9/11/12, 11/7/12, 11/20/12, 12/18/12, 2/25/13 and 4/23/13.

17 *See* McNamara Form 4s for 10/24/08, 11/10/08, 8/3/09 and 11/3/09.

222. The DOJ Complaint also provides additional evidence of scienter. *See* ¶¶90-91, 130-32.

M. Loss Causation/Economic Loss

223. During the Class Period, as detailed herein, Defendants engaged in a scheme to deceive the market and a course of conduct which artificially inflated the prices of Chemed common stock and operated as a fraud or deceit on Class Period purchasers of Chemed common stock. When Defendants' prior misrepresentations and ongoing, widespread fraudulent conduct were disclosed and became apparent to the market, the price of Chemed common stock fell precipitously as the prior artificial inflation came out. As a result of their purchases of Chemed common stock during the Class Period, Plaintiffs and the other Class members suffered economic loss, *i.e.*, damages, under the federal securities laws.

224. Defendants' false and misleading statements had the intended effect and caused Chemed common stock to trade at artificially inflated levels throughout the Class Period.

225. As a direct result of the revelations set forth above, and the corresponding drop in the price of Chemed's common stock, Lead Plaintiffs and Class members suffered real economic loss.

226. On November 16, 2011, among other things, it was disclosed that a former VITAS general manager revealed that the Company was engaging in an extensive scheme to defraud the federal government by enrolling Medicare patients in hospice who were not eligible. In addition, the scope of the ongoing federal investigations came to light. In response to these announcements, shares of the Company's stock fell $6.87 per share, or 11%, to close at $50.65 per share on November 16, 2011, on extremely heavy trading volume.

227. On May 2, 2013, among other things, it was disclosed that the DOJ filed the DOJ Complaint alleging violations of the federal False Claims Act against Chemed and VITAS, among

others. In response to these announcements, shares of the Company's stock price fell $13.79 per share to close at $68.00 per share, or 16.86%, on May 3, 2013, on extremely heavy trading volume.

228. The declines in the prices of Chemed common stock after the disclosures set forth above came to light were a direct result of the nature and extent of Defendants' fraud being revealed to investors and the market. The timing and magnitude of the price declines in Chemed common stock negate any inference that the losses suffered by Plaintiffs and the other Class members were caused by changed market conditions, macroeconomic or industry factors or Company-specific facts unrelated to Defendants' fraudulent conduct. During the Class Period, Defendants consistently touted VITAS' compliance with Medicare and Medicaid rules and regulations. On July 27, 2011, in response to a direct question from an analyst about similar wrongdoing discussed in an OIG report, Defendant O'Toole unequivocally stated: "We don't have that issue at all. We are very comfortable with where we sit." Accordingly, the information contained in the November 16, 2011 Bloomberg News article, and the news of the filing of the DOJ Complaint on May 2, 2013, came as a shock to the market, and the Company's stock drops reflected that. The economic loss, *i.e.*, damages, suffered by Plaintiffs and the other Class members was a direct result of Defendants' fraudulent scheme to artificially inflate the price of Chemed common stock and the subsequent significant declines in the value of Chemed common stock when Defendants' prior misrepresentations and other fraudulent conduct were revealed.

N. Applicability of Presumption of Reliance: Fraud on the Market Doctrine

229. At all relevant times, the market for Chemed common stock was an efficient market for the following reasons, among others:

(a) Chemed's stock met the requirements for listing, and was listed and actively traded on the NYSE, a highly efficient and automated market;

(b) as a regulated issuer, Chemed filed periodic public reports with the SEC and the NYSE;

(c) Chemed regularly communicated with public investors via established market communication mechanisms, including through regular disseminations of press releases on the national circuits of major newswire services and through other wide-ranging public disclosures, such as communications with the financial press and other similar reporting services; and

(d) Chemed was followed by several securities analysts employed by major brokerage firms who wrote reports which were distributed to the sales force and certain customers of their respective brokerage firms. Each of these reports was publicly available and entered the public marketplace.

230. As a result of the foregoing, the market for Chemed common stock promptly digested current information regarding Chemed from all publicly-available sources and reflected such information in the price of Chemed stock. Under these circumstances, all purchasers of Chemed common stock during the Class Period suffered similar injury through their purchase of Chemed common stock at artificially inflated prices and a presumption of reliance applies.

231. The market for Chemed common stock was open, well-developed and efficient at all relevant times. As a result of these materially false and misleading statements and failures to disclose, Chemed common stock traded at artificially inflated prices during the Class Period. Plaintiffs and other members of the Class purchased or otherwise acquired Chemed common stock relying upon the integrity of the market price of Chemed common stock and market information relating to Chemed, and have been damaged thereby.

232. During the Class Period, Defendants materially misled the investing public, thereby inflating the price of Chemed common stock, by publicly issuing false and misleading statements and omitting to disclose material facts necessary to make Defendants' statements, as set forth herein,

not false and misleading. Said statements and omissions were materially false and misleading in that they failed to disclose material adverse information and misrepresented the truth about the Company, its business and operations, as alleged herein.

233. At all relevant times, the material misrepresentations and omissions particularized in this Complaint directly or proximately caused or were a substantial contributing cause of the damages sustained by Plaintiffs and other members of the Class. As described herein, during the Class Period, Defendants made or caused to be made a series of materially false or misleading statements about Chemed's business, prospects and operations. These material misstatements and omissions had the cause and effect of creating in the market an unrealistically positive assessment of Chemed and its business, prospects and operations, thus causing the Company's common stock to be overvalued and artificially inflated at all relevant times. Defendants' materially false and misleading statements during the Class Period resulted in Plaintiffs and other members of the Class purchasing the Company's common stock at artificially inflated prices, thus causing the damages complained of herein. When the true facts about the Company were revealed to the market, the inflation in the price of Chemed stock was removed and the price of Chemed stock declined dramatically, causing loss to Plaintiffs and the other members of the Class.

O. No Safe Harbor

234. The statutory safe harbor provided for forward-looking statements under certain circumstances does not apply to any of the allegedly false statements pleaded in this Complaint. Many of the specific statements pleaded herein were not identified as "forward-looking statements" when made. To the extent there were any forward-looking statements, there were no meaningful cautionary statements identifying important factors that could cause actual results to differ materially from those in the purportedly forward-looking statements. Alternatively, to the extent that the statutory safe harbor does apply to any forward-looking statements pleaded herein, Defendants are

liable for those false forward-looking statements because at the time each of those forward-looking statements was made, the particular speaker knew that the particular forward-looking statement was false, and/or the forward-looking statement was authorized and/or approved by an executive officer of Chemed who knew that those statements were false when made.

COUNT I

Violation of Section 10(b) of the Exchange Act and Rule 10b-5 Promulgated Thereunder Against Chemed

235. Plaintiffs incorporate by reference and reallege each and every allegation contained above as if fully set forth herein.

236. During the Class Period, officers, management, and agents of Chemed carried out a plan, scheme and course of conduct which was intended to and, throughout the Class Period, did: (i) deceive the investing public regarding Chemed's business, operations, management and the intrinsic value of Chemed's common stock; (ii) enable Chemed to artificially inflate the price of Chemed's common stock; and (iii) cause Plaintiffs and other members of the Class to purchase Chemed's common stock at artificially inflated prices. In furtherance of this unlawful scheme, plan and course of conduct, Defendant Chemed took the actions set forth herein.

237. Officers, management, and agents of Chemed directly and indirectly, by the use of means and instrumentalities of interstate commerce, the mails, and/or the facilities of a national securities exchange: (a) employed devices, schemes, and artifices to defraud; (b) made untrue statements of material fact and/or omitted to state material facts necessary to make the statements made not misleading; and (c) engaged in acts, practices, and a course of business which operated as a fraud and deceit upon the purchasers of the Company's common stock in an effort to maintain artificially high market prices for Chemed's common stock in violation of Section 10(b) of the Exchange Act and SEC Rule 10b-5. Defendant Chemed is sued as a primary participant in the wrongful and illegal conduct charged herein.

238. Defendant Chemed, individually and in concert, directly and indirectly, by the use, means or instrumentalities of interstate commerce and/or of the mails, engaged and participated in a continuous course of conduct to conceal the truth about Chemed's VITAS segment, as specified herein.

239. Officers, management, and agents of Chemed employed devices, schemes, and artifices to defraud while in possession of material adverse non-public information and engaged in acts, practices, and a course of conduct as alleged herein in an effort to assure investors of Chemed's value and performance, which included the making of untrue statements of material facts and omitting material facts necessary in order to make the statements made about Chemed's operations and financial condition, in the light of the circumstances under which they were made, not misleading, as set forth more particularly herein. Officers, management, and agents of Chemed did not have a reasonable basis for their alleged false statements and engaged in transactions, practices, and a course of business which operated as a fraud and deceit upon the purchasers of Chemed common stock during the Class Period.

240. Chemed is liable for all materially false and misleading statements and omissions made during the Class Period, as alleged above, including the false and misleading statements and omissions included in Form 10-Q, 10-K, and 8-K filings.

241. Chemed is further liable for the false and misleading statements made by Chemed's officers, management, and agents in press releases and during conference calls and at conferences with investors and analysts, as alleged above, as the maker of such statements and under the principle of respondeat superior.

242. In addition to the duties of full disclosure imposed on Chemed as a result of the affirmative statements and reports made by its officers, management, and agents, or participation in the making of their affirmative statements and reports to the investing public, Chemed had a duty to

promptly disseminate truthful information that would be material to investors, in compliance with the integrated disclosure provisions of the SEC as embodied in SEC Regulations, including truthful, complete and accurate information with respect to the Company's operations and financial condition so that the Company's share price would be based on truthful, complete and accurate information.

243. The allegations above establish a strong inference that Chemed, as an entity, acted with corporate scienter throughout the Class Period, as its officers, management, and agents had actual knowledge of the misrepresentations and omissions of material facts set forth herein, or acted with reckless disregard for the truth because they failed to ascertain and to disclose such facts, even though such facts were available to them. Such material misrepresentations and/or omissions were done knowingly or with recklessness, and without a reasonable basis. By concealing these material facts from investors, Chemed maintained its artificially inflated share price throughout the Class Period.

244. In ignorance of the fact that Chemed's share price was artificially inflated, and relying directly or indirectly on the false and misleading statements and omissions made by Chemed, or upon the integrity of the market in which the stock traded, and/or on the absence of material adverse information that was known to or recklessly disregarded by Chemed but not disclosed in public statements by Chemed during the Class Period, Lead Plaintiffs and the other members of the Class purchased or acquired Chemed stock during the Class Period at artificially high prices and were damaged when that artificial inflation was removed from the price of Chemed stock as the truth about the Company's practices was revealed.

245. At the time of said misrepresentations and omissions, Lead Plaintiffs and other members of the Class were ignorant of their falsity, and believed them to be true. Had Lead Plaintiffs, the other members of the Class, and the marketplace known of the truth concerning VITAS' admissions growth and revenues and its scheme to enroll, and keep enrolled, ineligible

patients in hospice and fraudulently bill Medicare for inappropriate hospice services, Lead Plaintiffs and other members of the Class would not have purchased or acquired their Chemed stock, or, if they had purchased or acquired such stock during the Class Period, they would not have done so at the artificially inflated prices which they paid.

246. By virtue of the foregoing, Chemed has violated Section 10(b) of the Exchange Act and Rule 10b-5 promulgated thereunder.

247. As a direct and proximate result of Chemed's wrongful conduct, Lead Plaintiffs and the other members of the Class suffered damages in connection with their respective purchases and/or acquisitions of Chemed stock during the Class Period.

COUNT II

Violation of Section 10(b) of the Exchange Act and Rule 10b-5 Promulgated Thereunder Against the Individual Defendants

248. Plaintiffs incorporate by reference and reallege each and every allegation contained above as if fully set forth herein. This claim is asserted against Defendants McNamara, Williams and O'Toole.

249. During the Class Period, the Individual Defendants McNamara, Williams and O'Toole carried out a plan, scheme and course of conduct which was intended to and, throughout the Class Period, did: (i) deceive the investing public regarding Chemed's business, operations, management and the intrinsic value of Chemed's common stock; (ii) enable Chemed to artificially inflate the price of Chemed's common stock, and (iii) cause Plaintiffs and other members of the Class to purchase Chemed's common stock at artificially inflated prices. In furtherance of this unlawful scheme, plan and course of conduct, these Defendants took the actions set forth herein.

250. The Individual Defendants: (a) employed devices, schemes, and artifices to defraud; (b) made untrue statements of material fact and/or omitted to state material facts necessary to make the statements made not misleading; and (c) engaged in acts, practices, and a course of business

which operated as a fraud and deceit upon the purchasers of the Company's common stock in an effort to maintain artificially high market prices for Chemed's common stock in violation of Section 10(b) of the Exchange Act and SEC Rule 10b-5. The Individual Defendants are sued as primary participants in the wrongful and illegal conduct charged herein and/or as controlling persons as alleged below.

251. The Individual Defendants, individually and in concert, directly and indirectly, by the use, means or instrumentalities of interstate commerce and/or of the mails, engaged and participated in a continuous course of conduct to conceal the truth about Chemed's VITAS segment, as specified herein.

252. The Individual Defendants employed devices, schemes, and artifices to defraud while in possession of material adverse non-public information and engaged in acts, practices, and a course of conduct as alleged herein in an effort to assure investors of Chemed's value and performance, which included the making of untrue statements of material facts and omitting material facts necessary in order to make the statements made about Chemed's operations and financial condition, in the light of the circumstances under which they were made, not misleading, as set forth more particularly herein, and engaged in transactions, practices, and a course of business which operated as a fraud and deceit upon the purchasers of Chemed common stock during the Class Period.

253. The Individual Defendants had actual knowledge of the misrepresentations and omissions of material facts set forth herein, or acted with reckless disregard for the truth in that they failed to ascertain and to disclose such facts, even though such facts were available to them. Such Defendants' material misrepresentations and/or omissions were done knowingly or recklessly and for the purpose and effect of concealing Chemed's practices from the investing public and supporting the artificially inflated price of its common stock. As demonstrated by these Defendants' misstatements and omissions of the Company's VITAS business throughout the Class Period, these

Defendants, if they did not have actual knowledge of the misrepresentations and omissions alleged, were reckless in failing to obtain such knowledge by deliberately refraining from taking those steps necessary to discover whether those statements were false or misleading.

254. As a result of the dissemination of the materially false and misleading information and failure to disclose material facts, as set forth above, the market price of Chemed's common stock was artificially inflated during the Class Period. In ignorance of the fact that market prices of Chemed's publicly-traded common stock were artificially inflated, and relying directly or indirectly on the false and misleading statements made by these Defendants, or upon the integrity of the market in which the common stock trades, and/or on the absence of material adverse information that was known to or recklessly disregarded by these Defendants but not disclosed in public statements during the Class Period, Plaintiffs and the other members of the Class acquired Chemed's common stock during the Class Period at artificially high prices and were damaged when the value of their common stock declined upon disclosure of the truth about the Company's false and misleading statements and omissions.

255. At the time of said misrepresentations and omissions, Lead Plaintiffs and other members of the Class were ignorant of their falsity, and believed them to be true. Had Lead Plaintiffs, the other members of the Class, and the marketplace known of the truth concerning VITAS' admissions growth and revenues and its scheme to enroll, and keep enrolled, ineligible patients in hospice and fraudulently bill Medicare for inappropriate hospice services, Lead Plaintiffs and other members of the Class would not have purchased or acquired their Chemed stock, or, if they had purchased or acquired such stock during the Class Period, they would not have done so at the artificially inflated prices which they paid.

256. By virtue of the foregoing, the Individual Defendants have violated Section 10(b) of the Exchange Act and Rule 10b-5 promulgated thereunder.

257. As a direct and proximate result of Chemed's wrongful conduct, Lead Plaintiffs and the other members of the Class suffered damages in connection with their respective purchases and/or acquisitions of Chemed stock during the Class Period.

COUNT III

Violation of Section 20(a) of the Exchange Act Against the Individual Defendants

258. Plaintiffs repeat and reallege each and every allegation contained above as if fully set forth herein.

259. The Individual Defendants acted as controlling persons of Chemed within the meaning of Section 20(a) of the Exchange Act as alleged herein. By reason of their positions as officers and/or directors of Chemed, and their ownership of Chemed stock, the Individual Defendants had the power and authority to cause Chemed to engage in the wrongful conduct complained of herein. By reason of such conduct, the Individual Defendants are liable pursuant to Section 20(a) of the Exchange Act.

WHEREFORE, Plaintiffs pray for relief and judgment, as follows:

A. Determining that this action is a proper class action, certifying Plaintiffs as class representatives and designating Lead Counsel as Class Counsel under Rule 23 of the Federal Rules of Civil Procedure;

B. Awarding compensatory damages in favor of Plaintiffs and the other Class members against all Defendants, jointly and severally, for all damages sustained as a result of Defendants' wrongdoing, in an amount to be proven at trial, including interest thereon;

C. Awarding Plaintiffs and the Class their reasonable costs and expenses incurred in this action, including counsel fees and expert fees; and

D. Such other and further relief as the Court may deem just and proper.

JURY TRIAL DEMANDED

Plaintiffs hereby demand a trial by jury.

DATED: February 6, 2014

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EXHIBIT A

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF MISSOURI
WESTERN DIVISION

UNITED STATES OF AMERICA, Plaintiff, v. VITAS HOSPICE SERVICES, L.L.C., VITAS HEALTHCARE CORPORATION, VITAS CARE SOLUTIONS, INC., VITAS HEALTHCARE CORPORATION OF CALIFORNIA, VITAS HEALTHCARE CORPORATION OF ILLINOIS, VITAS HEALTHCARE CORPORATION OF FLORIDA, VITAS HEALTHCARE CORPORATION OF OHIO, VITAS HEALTHCARE CORPORATION OF ATLANTIC, VITAS HEALTHCARE OF TEXAS, L.P., VITAS HEALTHCARE CORPORATION MIDWEST, VITAS HEALTHCARE CORPORATION OF GEORGIA, VITAS HME SOLUTIONS, INC., VITAS OF NORTH FLORIDA, VITAS HOLDINGS CORPORATION, VITAS RT, INC., VITAS SOLUTIONS, INC., HOSPICE CARE INC., CHEMED CORPORATION, AND COMFORT CARE HOLDINGS CO., Defendants.	Case No. _____

UNITED STATES' COMPLAINT

The United States of America, by and through its undersigned counsel, alleges as follows:

I. Introduction

1. The United States brings this False Claims Act action against the publicly-traded company Chemed Corporation ("Chemed") and its subsidiaries named above (collectively referred to in this Complaint as "Vitas"), to recover losses sustained by the Medicare Program.

2. Medicare is a federally-funded program that provides medical insurance for certain items and services to qualified people. In addition to paying for doctor visits, nursing home care, and hospital stays, Medicare offers a hospice benefit for eligible Medicare beneficiaries. Hospice care services include palliative care, or care to relieve the pain, symptoms, and stress for Medicare beneficiaries who are expected to die within six months. Hospice care services are intended to include a comprehensive set of medical, social, psychological, emotional, and spiritual services.

3. Hospice companies like Vitas are entitled to receive Medicare dollars only for hospice services provided to patients who are "terminally ill." An individual is "terminally ill" if he or she has a medical prognosis of six months or less if the individual's illness runs its normal course. 42 C.F.R. § 418.3. Electing the Medicare hospice benefit is a critical decision for an individual because he or she is electing to cease further curative care for his or her illness.

4. Hospices are paid a per diem rate based on the number of days and level of care provided to the patient. Medicare recognizes and provides reimbursement for four levels of hospice care: routine home care, continuous home care, inpatient respite care, and general inpatient care. The payment rates are based on which level of care the hospice provider furnishes to a patient on a particular day. 42 C.F.R. § 418.302; Medicare Benefit Policy Manual, Chapter 9, § 40.

5. Most hospice care is and should be billed as routine home care. Hospice providers receive the highest daily rate of reimbursement for continuous home care services (also called "crisis care"). Crisis care is available only for patients who are experiencing an acute crisis that requires the immediate and short-term provision of skilled nursing services. In fiscal

year 2013, Medicare's daily reimbursement rate for crisis care was $742 more per patient than the daily reimbursement rate for routine home care.

6. Chemed has historically owned and operated Roto-Rooter Group, Inc., a national drain cleaning and plumbing service. Chemed expanded into the hospice business in 2004 when it acquired the Vitas-affiliated companies, which had been in operation since 1978. Vitas is now the largest for-profit hospice chain in the United States and, according to its website, provides hospice services to patients residing in their own homes, assisted living facilities, skilled nursing facilities, hospitals unaffiliated with Vitas, and 36 inpatient units. Chemed finances its hospice operations largely through receipt of Medicare dollars. Historically, approximately 90 percent of Vitas's revenue is derived from the Medicare program. According to Chemed's 2012 Annual Report to Shareholders, Vitas received over one billion dollars in revenue in 2012.

7. The United States alleges in this action that Vitas focused on maximizing Medicare reimbursement for as many patients as possible while disregarding patients' medical needs and Medicare guidelines. Vitas regularly ignored concerns expressed by its own physicians and nurses regarding whether its hospice patients were receiving appropriate care.

8. Vitas's business and marketing practices led to increased Medicare billings for costly crisis care services, even though its patients often did not need such medical care or were not eligible for this type of medical care. Chemed's internal auditors and Vitas's employees were aware of these problems, yet the problems continued to persist, even to this day.

9. Specifically, the United States alleges that, since at least 2002, Vitas, and since at least 2004 Chemed (after acquiring Vitas), submitted or caused the submission of false claims to the Medicare program by both: (a) billing Medicare for more costly crisis care services when certain patients did not need crisis care services or when Vitas, in fact, did not provide such

services, or Vitas provided inappropriate medical care, and (b) admitting certain patients who were not eligible to receive hospice services (instead of curative care), because the patients did not have a life expectancy of six months or less if their illnesses ran their normal course. Chemed and Vitas also submitted or caused to be submitted fraudulent records and statements in support of their false claims for payment to the Medicare Program.

10. As a result of this conduct, Chemed and Vitas are liable under the False Claims Act, 31 U.S.C. § 3729, *et seq*.

II. Jurisdiction and Venue

11. This Court has subject matter jurisdiction over this action pursuant to 28 U.S.C. §§ 1331 and 1345, and supplemental jurisdiction to entertain common law or equitable claims pursuant to 28 U.S.C. § 1367(a).

12. This Court has personal jurisdiction over Vitas and Chemed pursuant to 31 U.S.C. § 3732(a). Jurisdiction is proper over Vitas and Chemed because they can be found in, reside in, and/or have transacted business within this Court's jurisdiction, and acts that they committed, in violation of 31 U.S.C. § 3729, occurred within this district.

13. Venue is proper in this district under 28 U.S.C. §§ 1391(b)-(c), and 31 U.S.C. § 3732(a) because Vitas and Chemed reside in or transact business in this district.

III. The Parties

14. Plaintiff in this action is the United States of America, suing on behalf of the United States Department of Health & Human Services ("HHS") and, specifically, its operating division, the Centers for Medicare & Medicaid Services ("CMS"). At all times relevant to this Complaint, CMS was an operating division of HHS that administered and supervised the Medicare Program.

15. Defendant Chemed, a Delaware Corporation, shares of which are listed on the New York Stock Exchange, is headquartered in Cincinnati, Ohio.

16. Defendant Chemed also wholly owns Chemed RT, Inc., and Comfort Care Holdings Co.

17. Defendant Comfort Care Holdings Co. wholly owns subsidiaries that operate Vitas's for-profit hospices nationwide, including Defendants Vitas Hospice Services, L.L.C., Vitas Healthcare Corporation, Vitas Care Solutions, Inc., Vitas Healthcare Corporation of California, Vitas Healthcare Corporation of Illinois, Vitas Healthcare Corporation of Florida, Vitas Healthcare Corporation of Ohio, Vitas Healthcare Corporation of Atlantic, Vitas Healthcare of Texas, L.P., Vitas Healthcare Corporation Midwest, Vitas Healthcare Corporation of Georgia, Vitas HME Solutions, Inc., Vitas of North Florida, Vitas Holdings Corporation, Vitas RT, Inc., Vitas Solutions Inc., and Hospice Care Inc.

18. Vitas's operations are based in Miami, Florida. Vitas operates 51 for-profit hospice programs in 18 states (Alabama, California, Colorado, Connecticut, Delaware, Florida, Georgia, Illinois, Indiana, Kansas, Michigan, Missouri, New Jersey, Ohio, Pennsylvania, Texas, Virginia and Wisconsin) and the District of Columbia. At all times relevant to this Complaint, Vitas was engaged in the business of providing hospice care to individuals who were Medicare beneficiaries.

IV. The False Claims Act

19. The False Claims Act provides, in part, that any entity that (1) knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval; or (2) knowingly makes, uses, or causes to be made or used, a false record or statement material to a

false or fraudulent claim, is liable to the United States for damages and penalties. 31 U.S.C. §§ 3729(a)(1)-(2), amended by, 31 U.S.C. §§ 3729(a)(1)(A)-(B).

20. To show that an entity acted "knowingly" under the False Claims Act, the United States must prove that the entity, with respect to the information: (1) has actual knowledge of the information; (2) acts in deliberate ignorance of the truth or falsity of the information; or (3) acts in reckless disregard of the truth or falsity of the information. The United States does not have to prove that the entity had the specific intent to defraud the United States. 31 U.S.C. § 3729(b), amended by 31 U.S.C. § 3729(b)(1).

V. The Medicare Hospice Program

A. Hospice Services Covered

21. Title XVIII of the Social Security Act, 42 U.S.C. §§ 1395, *et seq.*, establishes the Health Insurance for the Aged and Disabled Program, commonly referred to as the Medicare Program (or "Medicare").

22. The Medicare Program is comprised of four parts. Medicare Part A is a 100 percent federally-funded health insurance program for qualified individuals aged 65 and older, younger people with qualifying disabilities, and people with End Stage Renal Disease (permanent kidney failure requiring dialysis or transplant). The majority of Medicare Part A's costs are paid by United States citizens through their payroll taxes. The benefits covered by Medicare Part A include hospice care under 42 U.S.C. § 1395x(dd).

23. Hospice is a program designed to provide patients with palliative care (i.e., care designed to relieve pain, symptoms or stress of terminal illness) instead of curative care (i.e., care designed to cure an illness or condition). Hospice palliative care includes a comprehensive set of medical, social, psychological, emotional, and spiritual services for terminally ill individuals. To be covered, hospice services must be reasonable and necessary for the palliation

and management of a patient's terminal illness as well as related conditions. Medicare outlines the admission criteria for various illnesses.

24. Hospice is available to terminally ill individuals for two initial 90-day periods, and then an unlimited number of 60-day periods, as long as certain conditions are met, as described later. Medicare Benefit Policy Manual, Chapter 9, §§ 10, 20.1.

25. Crisis care is for a patient who elects to receive hospice care at home, or in a long-term care facility such as a nursing home. Crisis care is provided when the (at-home or nursing home) hospice patient is experiencing a "brief period[] of crisis," and only as necessary to allow the patient to remain at their residence. 42 C.F.R. § 418.302(b)(2). Medicare defines a brief "period of crisis" as "a period in which the individual requires continuous care to achieve palliation and management of acute medical symptoms." *Id*. at § 418.204(a).

26. To bill Medicare for crisis care, a hospice must provide care that is: (1) designed to palliate the patient's acute medical symptoms, (2) provided to the patient for at least eight hours in a 24-hour period, counted from midnight to midnight, and (3) predominantly nursing care, meaning care provided by a registered nurse (RN), licensed practical nurse (LPN), or nurse practitioner (NP). *See* 42 C.F.R. §§ 418.302, 418.204. If the care lasts less than eight hours in a 24-hour period, the hospice may only bill Medicare for routine home care for that day of hospice services. Similarly, if the care provided does not consist of predominantly nursing care, the hospice may not bill Medicare for crisis care and must instead bill for routine home care. *See id.*

B. Eligibility For Hospice Services

27. In order to be eligible to elect hospice care under Medicare, an individual must be (a) entitled to Part A of Medicare; and (b) certified as terminally ill in accordance with 42 C.F.R. § 418.22. *See* 42 U.S.C. § 1395f(7)(A); 42 C.F.R. § 418.20. According to 42 C.F.R. § 418.3,

"terminally ill" means that a person "has a medical prognosis that his or her life expectancy is 6 months or less if the illness runs its normal course."

28. Medicare beneficiaries must elect hospice care (i.e., it is *voluntary*) and in doing so agree to forego curative treatment of their terminal illnesses. Patients who receive the Medicare hospice benefit no longer receive care that seeks to cure their illnesses. For this reason, electing hospice care is a critical medical decision for a patient who has been informed that his or her death is imminent.

C. Obligations of the Hospice Provider

29. All Medicare providers are expected to deal honestly with the Government and with patients.

30. In addition, all healthcare providers like Vitas are obligated to comply with applicable statutes, regulations, and guidelines in order to be reimbursed by Medicare under what is known as "Part A," as described above. When participating in Medicare, a provider has a duty to be knowledgeable of the statutes, regulations, and guidelines for coverage of Medicare services, and, in the case of hospice care, to know that Medicare only reimburses for services that are reasonable and necessary for the palliation or management of terminal illness. 42 U.S.C. § 1395y(a)(1)(C).

31. Vitas, a Medicare provider that received close to a billion dollars last year from hospice revenue, the overwhelming majority of which was paid by Medicare, has a duty to have a thorough knowledge of the Medicare hospice program, and to properly train and inform its employees regarding the requirements for Medicare coverage of hospice services.

32. One of the purposes of the Medicare hospice requirements is to ensure that limited Medicare funds are properly spent on patients who are dying and need end of life care.

33. To bill for hospice care, the hospice provider must ensure that a patient is terminally ill before the individual is faced with the decision to stop receiving medical care that could cure his or her illness. The hospice provider must have a written certification of terminal illness that, among other things, includes: (1) a statement that the individual's medical prognosis is that his or her life expectancy is six months or less if the terminal illness runs its normal course; (2) specific clinical findings and other documentation that support a determination that the patient has a life expectancy of six months or less; and (3) the signature(s) of the physician(s) attesting to these medical conclusions. 42 C.F.R. § 418.22.

34. In addition to the Medicare regulations, these important requirements are also contained in the Medicare Benefit Policy Manual, Chapter 9, § 20.1, along with additional descriptions and guidance for hospice providers.

35. Recognizing the gravity of a patient's decision to forgo curative care for a terminal illness, Medicare instructs that "a hospice needs to be certain that the physicians' clinical judgment can be supported by clinical information and other documentation that provide a basis for the certification of six months or less if the illness runs its normal course. A signed certification, absent a medically sound basis that supports the clinical judgment, is not sufficient for application of the hospice benefit under Medicare." 170 Fed. Reg. 70534-35.

36. Medicare requires that at least eight hours of primarily nursing care are needed to manage an acute medical crisis. Furthermore, "[w]hen a hospice determines that a beneficiary meets the requirements for [crisis care], appropriate documentation must be available to support the requirement that the services provided were reasonable and necessary and were in compliance with an established plan of care in order to meet a particular crisis situation. This

would include the appropriate documentation of the situation and the need for continuous care services consistent with the plan of care." Medicare Benefit Policy Manual, Chapter 9, § 40.2.1.

37. The clinical record for each hospice patient must contain "correct clinical information." 42 C.F.R. § 418.104. All entries in the clinical record must be "legible, clear, complete, and appropriately authenticated and dated…." 42 C.F.R. § 418.104(b).

38. For the initial 90-day period, the hospice provider must obtain a certification of terminal illness for the patient from both (a) the medical director of the hospice or a physician-member of the hospice interdisciplinary group, and (b) the individual's attending physician, if the individual has an attending physician. For subsequent periods, the hospice provider must obtain the certification of terminal illness from either the medical director of the hospice or a physician who is a member of the hospice's interdisciplinary group for the patient. 42 U.S.C. § 1395f(7)(A); 42 C.F.R. § 418.22.

39. As specified by 42 C.F.R. § 418.56, the interdisciplinary group should consist of, at a minimum, a physician, a registered nurse, a social worker, and a pastor or other counselor. The interdisciplinary group is responsible for coordination of each patient's care, to ensure continuous assessment of each patient's and family's needs, and the implementation of the interdisciplinary plan of care.

D. The Medicare Hospice Payment Process

40. The United States reimburses Medicare providers with payments from the Medicare Trust Fund, through CMS, as supported by American taxpayers. CMS, in turn, contracts with Medicare Administrative Contractors ("Medicare claims processors," also known as "MACs"), to review, approve, and pay Medicare bills, called "claims," received from health care providers like Vitas. In this capacity, the Medicare claims processors act on behalf of CMS.

41. Payments are typically made by Medicare directly to health care providers like Vitas rather than to the patient. The Medicare beneficiary usually assigns his or her right to Medicare payment to the provider.

42. The Medicare provider either submits its bill directly to Medicare for payment, or it contracts with an independent billing company to submit a bill to the Medicare claims processor, on the provider's behalf.

43. Since 2002, Palmetto GBA (Palmetto) has been the Medicare claims processor that is responsible for processing the claims that Vitas submitted to obtain Medicare payments for hospice services.

44. Palmetto provides guidance to hospice providers on the medical criteria for determining whether individuals with certain diagnoses have a prognosis of six months or less, and such guidance is publicly available.

45. Palmetto also provides publicly available guidance to help hospice providers determine when crisis care is appropriate.

46. In addition, Palmetto offers training and assistance to hospice providers on the Medicare requirements.

47. Because it is not feasible for the Medicare program, or its contractors, to review the patient files for the millions of claims for payments it receives from hospice providers, the Medicare program relies upon the hospice providers to comply with the Medicare requirements, and trusts the providers to submit truthful and accurate claims. Hospice providers are reimbursed based upon their submission of a single electronic or hard-copy form called a "CMS-1450 form."

48. All Medicare providers must have, in each of their patients' files, the medical documentation to establish that the Medicare items or services for which they have sought Medicare reimbursement are reasonable and medically necessary.

49. The physician certifications and other documents that support the claim that hospice providers make to Medicare are submitted to Medicare only if the claim for hospice services is selected for medical review, which does not happen routinely. *See generally* Medicare Claims Processing Manual, Chap. 11, Processing Hospice Claims, and Medicare Program Integrity Manual, Chap. 3, *Verifying Potential Errors and Taking Corrective Actions*. Additionally, it is the hospice provider like Vitas and not the patient's primary care or treating physician, who is required to submit to Medicare the underlying documentation that supports the eligibility determination and the claim.

50. Once the provider submits its CMS-1450 form to the Medicare claims processor, the claims are paid directly to the provider.

51. On the CMS-1450 form, the hospice provider must state, among other things, the identity of the patient, the hospice's provider number, the patient's principal diagnosis, the date of the patient's certification or re-certification as "terminally ill," the location where hospice services were provided, and the level of hospice care provided (i.e., routine home care, crisis care, respite care, or general inpatient care).

52. On the claim form, the provider also certifies that the claim "is correct and complete," that "[p]hysician's certifications and re-certifications, if required by contract or Federal regulations, are on file," and that "[r]ecords adequately disclosing services will be maintained and necessary information will be furnished to government agencies as required by applicable law."

53. Federal law requires providers like Vitas that receive funds under the Medicare program, to report and return any overpayments within specified time periods. 42 U.S.C. § 1320a-7k(d).

VI. Chemed and Vitas Submitted or Caused to be Submitted False and Fraudulent Claims for Crisis Care.

54. Chemed and Vitas knowingly submitted false or fraudulent claims, or caused the submission of false claims, for crisis care services that were not actually provided to patients, that were inappropriately provided to patients, or that were not medically necessary because the patients were not in crisis during the periods that Vitas claimed it provided crisis care. Those false claims were paid by Medicare. Such services were not reasonable and medically necessary under the Medicare requirements.

55. Chemed and Vitas disregarded Medicare regulations in order to increase their reimbursement by Medicare for crisis care services, which they knew Medicare reimbursed at a higher level than other hospice services.

A. Chemed's and Vitas's Business Practices Led to the Submission of False or Fraudulent Claims for Crisis Care

56. Chemed's and Vitas's business practices led to the submission of false or fraudulent claims to Medicare for hospice services that were not reasonable or necessary under the Medicare hospice requirements.

57. Chemed and Vitas used aggressive marketing tactics and expected their employees to increase the number of crisis care claims submitted to Medicare, without regard to whether the crisis care services were appropriate for patients, or whether Vitas was actually providing the crisis care services to patients when it billed Medicare for those services. In some instances discussed below, Vitas's care provided to patients was inappropriate.

58. Vitas marketed crisis care services to patients and their families as "intensive comfort care" services, without mentioning that in order to bill Medicare for these services at the higher rates, a patient had to be experiencing a short-term crisis and have acute medical symptoms. One of Vitas's marketing brochures states that "intensive comfort care" is available for "symptoms causing distress to the patient or family."

59. Vitas knowingly misled patients and their families to believe that the Medicare hospice benefit would routinely cover around-the-clock care for hospice patients, absent the requisite acute medical symptoms resulting in brief periods of crisis that must be present for crisis care to be covered by Medicare. Because of this marketing ploy, patients sometimes chose Vitas over other providers, although the Medicare benefit is the same for patients regardless of the hospice program they choose. Vitas used similarly misleading techniques when it marketed its hospice services to potential referral sources of future hospice patients, such as physicians, nursing homes, and hospitals.

60. Vitas and Chemed management regularly corresponded with Vitas field offices about each office's crisis care utilization, particularly when the crisis care rates were lower than Defendants wanted. For example, on January 18, 2007, Vitas's Vice President of Operations sent an email to a marketing employee and General Manager in one of Vitas's Texas locations, stating: "Your program's CC [crisis care] margin dropped to [0.3 percentage] in December. Would you give me your thoughts on what caused this drop and what you will be doing to correct this in January? I will need this analysis by the end of the day today."

61. Defendants did not ensure that Vitas's medical staff were properly trained on the Medicare requirements for crisis care.

62. Vitas distributed written materials to its own staff that incorrectly trained them on how and when to initiate crisis care. For example, one Vitas document called "Procedure for Starting Crisis Care" outlines a procedure inconsistent with Medicare regulations, because it instructs Vitas employees that crisis care may commence without a physician's order.

63. One former medical director of a Vitas facility incorrectly believed that Vitas could bill Medicare for crisis care if the patient was "actively dying," a term not used anywhere in the Medicare requirements for crisis care. All patients who receive hospice care and elect to forgo curative care should have a life expectancy of six months or less if their illnesses run their normal course, but not all hospice patients are expected to experience periods of crisis requiring crisis care.

64. One Vitas nurse stated that, on more than one occasion when Vitas sent her to the homes of patients whom she was told needed crisis care, she arrived ready to perform intensive nursing care only to find that the patients were at church, the beauty parlor, or playing bingo. Despite the fact that these patients did not require or receive crisis care services, Vitas billed Medicare for crisis care for these patients.

65. Chemed set goals for the number of crisis care days that it wanted Vitas to bill to Medicare, and was directly involved in making decisions about how Vitas would market its crisis care services.

66. As a result, Chemed and Vitas set aggressive goals for Vitas's salespeople and other staff to find beneficiaries for whom they could bill Medicare for crisis care, and Vitas billed Medicare excessively for crisis care.

67. There are even specific instances, one of which is described below, where Vitas's medical records suggest that Vitas's failure to medically address a patient's symptom resulted in

a patient suffering from acute medical symptoms for an extended period of time, allowing Vitas to bill Medicare for the "crisis care" services necessary to address the patient's crisis that Vitas itself had caused.

68. Chemed and Vitas knew that they were submitting false billings for crisis care services to Medicare.

69. Since at least 2007, Chemed and Vitas conducted regular internal audits or program reviews that included a review of Vitas's crisis care services. Through these internal audits, Chemed and Vitas were made aware of patients (1) who were receiving crisis care services, but did not qualify for such services, (2) for whom services were billed to Medicare as "crisis care services", but the services were inconsistent with the patients' medical plans of care or with Medicare requirements, (3) for whom Vitas's own medical records showed were not in crisis.

70. By way of example, a document dated September 2010, and entitled, "Patient Care Documentation and Compliance Internal Review" for the San Fernando, California Vitas hospice program, showed that Vitas reviewed crisis care medical records for this hospice program. Only 50 percent of the records showed that Vitas was being consistent with Medicare's criteria for crisis care. Only 10 percent of the crisis care claims comported with the patients' plans of care set forth by Vitas medical teams. After reviewing multiple factors, the audit team gave the crisis care claims in this location a 69 percent score, indicating a significant deficiency in compliance with Medicare requirements.

71. Chemed and Vitas were also aware that their Medicare billings for crisis care were excessive as compared to other hospices, yet their billings to Medicare did not decrease.

72. The National Hospice and Palliative Care Organization (NHPCO) releases annual reports regarding hospice operations. It is clear from their historical data that Vitas obtains Medicare reimbursement for crisis care far exceeding that of the rest of the hospice industry. The size of Vitas alone does not explain its high Medicare expenditures for crisis care. Vitas bills Medicare for twice as many crisis care days as all other hospice providers combined.

73. According to Chemed's financial reporting and data published by NHPCO, for the period 2004 through 2011, Vitas's percentage of days of service for crisis care ranged from 4.42 percent to 5.25 percent, while the national average ranged from 0.4 percent to 1.2 percent.

74. According to Chemed's Annual Reports released between 2004 and 2012, Vitas received between $458.2 million and $1.067 billion in revenue, of which between $78.6 million and $172 million annually was for crisis care.

75. Vitas's total revenue for crisis care between 2004 and 2011 was $999.654 million. Additionally, during the time period 2004 through 2011, Vitas's net revenue for crisis care as a percentage of total revenue averaged between 15.3 percent and 17.2 percent, while the net crisis care revenue as a percentage of total hospice revenues nationwide during the period 2003 through 2005 (the last years for which data could be obtained) ranged from 1.6 percent to 1.8 percent.

76. Vitas's crisis care billings are almost six times what would be expected if its crisis care figures were in line with the national average.

77. Despite internal auditing, publicly-available data showing excessive crisis care claims, and Chemed's and Vitas's knowledge that they were submitting or causing the submission of false claims for crisis care services, the companies continued to excessively bill Medicare and aggressively market these Medicare services.

B. Examples of False Claims for Crisis Care Services [1]

78. Chemed and Vitas knowingly submitted or caused the submission of false or fraudulent claims to the Medicare program for the following patients, and Medicare paid these claims.

i. Patient EF

79. Chemed and Vitas knowingly submitted or caused to be submitted false or fraudulent claims to Medicare for seven days of crisis care for patient EF who was diagnosed with dementia and receiving hospice care in Illinois. These claims were false or fraudulent because Vitas's medical records for patient EF show that EF was not in crisis and because Vitas administered what would be considered routine hospice care services, even though Vitas billed Medicare at the higher crisis care rate.

80. Vitas's medical records do not indicate that EF was in "crisis" that required nursing care to palliate acute symptoms. The following is shown by Vitas's medical records for EF.

81. Vitas's own assessments of EF's symptoms, documented in EF's medical files, showed that EF was not in crisis and did not need crisis care.

82. On the same date that Vitas began billing Medicare for crisis care for EF for what Vitas referred to as "pain and dyspnea," Vitas rated EF's pain level at zero, and a Vitas nurse wrote in EF's record that all care plans were "effective."

83. Vitas's records also indicated that EF's respiratory rate was normal. Even if EF had been experiencing symptoms of pain and dyspnea, these symptoms should have been

[1] To protect patient privacy, the United States has not identified by name the individuals who are provided as examples of patients whom Vitas knew were not eligible for crisis care though it continued to bill Medicare. The United States will serve Vitas with a list identifying each patient by name and patient identification number.

effectively managed with standard oral medications and billed at the lower rate of routine home care.

84. Vitas administered small and occasional doses of morphine to patient EF, which Vitas should have billed to Medicare as routine home care.

85. Chemed and Vitas knowingly submitted or caused the submission of false or fraudulent claims numbered 20710000791305 and 20711301007904 to Medicare for crisis care services for patient EF that were not necessary or not provided for the time period March 29, 2007 through April 4, 2007, in the amounts of $2005.47 and $2522.16; and Medicare paid the claims on April 16, 2007 and April 26, 2007.

ii. Patient MJ

86. Chemed and Vitas knowingly submitted or caused to be submitted false or fraudulent claims to Medicare for two separate periods of crisis care for MJ, a patient in Virginia, in September and October 2009. These claims were false or fraudulent because Vitas's medical records for patient MJ show that MJ was not in crisis and because Vitas administered what would be considered routine hospice care, even though Vitas billed Medicare at the higher crisis care rate on behalf of MJ.

a) Crisis Care Billing Period 1

87. The first period of time for which Vitas billed Medicare for crisis care for MJ is for the time period from September 8, 2009 through September 11, 2009.

88. Vitas's medical records for that time period do not indicate that MJ was in "crisis" that required nursing care to palliate acute symptoms. The following is shown by Vitas's medical records for MJ.

89. On September 8, 2009, the same date that Vitas began billing Medicare for crisis care for MJ for what Vitas referred to as "shortness of breath," the nursing assessment that Vitas completed shows that MJ's vital signs, including her respiratory rate, were normal, and there was no indication that she was suffering from shortness of breath. Vitas's nursing assessments completed on the following day, September 9, 2009, showed the same normal respiratory rate and no signs that MJ was experiencing shortness of breath.

90. There is also nothing in Vitas's medical records for MJ to suggest that Vitas performed any intervention to manage shortness of breath symptoms during the same time period, except one brief episode, noted below.

91. Even if MJ had been experiencing shortness of breath, these symptoms should have been effectively managed by Vitas and billed to Medicare as routine home care.

92. For example, on September 10, 2009, the third day on which Vitas billed Medicare for crisis care for MJ, Vitas's medical records for MJ show that MJ had one episode of shortness of breath and that Vitas administered routine medications, and an additional dose of morphine and anti-anxiety medications. Administration of these medications did not qualify as crisis care and Vitas should have billed Medicare on behalf of MJ for routine home care.

93. In addition, on September 10, 2009, the Vitas chaplain who visited MJ made a note in MJ's medical records that Vitas was billing Medicare for crisis care for MJ on the basis of what Vitas referred to as "transition." Other Vitas staff also made notes in MJ's file indicating that "transition" was the reason Vitas billed Medicare for crisis care for MJ.

94. Vitas did not define the meaning of "transition," and transition does not have a recognized medical meaning or otherwise qualify as a basis for a hospice company to bill Medicare for crisis care. If "transition" is meant to refer to an event where a hospice patient is

transported from one care setting to another, that event should be billed to Medicare as routine services.

95. Chemed and Vitas knowingly submitted or caused the submission of false or fraudulent claim numbered 20929500743405VAR to Medicare for crisis care services to patient MJ that were not necessary or not provided for the time period September 8, 2009 through September 11, 2009, in the amount of $2810.18; and Medicare paid the claims on October 26, 2009.

b) Crisis Care Billing Period 2

96. The second period of time for which Vitas billed Medicare for crisis care for MJ is for the time period from October 10, 2009 through October 12, 2009.

97. Vitas billed Medicare for crisis care services for MJ again for the stated reason of shortness of breath. And again, MJ's medical records do not support Vitas's claim that MJ was experiencing shortness of breath. In fact, to the contrary, MJ's medical records during this time period state that she was agitated and screaming loudly.

98. On October 10, 2009, MJ received a nebulizer treatment, which Vitas should have billed Medicare as routine home care.

99. Rather than experiencing an acute crisis requiring crisis care, Vitas's medical records for October 10, 2009, show that MJ was playing bingo in the activity room.

100. Vitas's medical records for MJ for October 11 and 12, 2009 contain various nursing notes with inconsistent information regarding MJ's condition, none of which indicate that MJ was experiencing acute symptoms or a medical crisis. One note states that MJ was screaming loudly, one states that that she was short of breath, another note states that MJ's respirations were unlabored, and yet another note indicates that she was "comfortable."

101. MJ's agitation and screaming episodes should have been effectively treated as routine home care, and Vitas should have billed Medicare for routine home care.

102. Chemed and Vitas knowingly submitted or caused the submission of false or fraudulent claims to Medicare for crisis care services to patient MJ that were not necessary or not provided for the time period October 10, 2009 through October 12, 2009, in the amount of approximately $2,000; and Medicare paid the claims.

iii. Patient TS

103. Chemed and Vitas knowingly submitted or caused to be submitted claims to Medicare for crisis care for three separate time periods for patient TS, a patient in Florida, in March 2006, April 2006, and May to June 2006. These claims were false or fraudulent because Vitas's medical records for patient TS show that TS was not in crisis, and because Vitas administered what would be considered routine hospice care to TS, even though Vitas billed Medicare at the higher crisis care rate.

104. Vitas's medical records do not indicate that TS was in "crisis" that required nursing care to palliate acute symptoms. The following is shown by Vitas's medical records.

a) Crisis Care Billing Period 1

105. Vitas billed Medicare for crisis care for TS for the time period from March 19, 2006 through March 21, 2006.

106. Vitas's medical records for TS state TS's increased weakness, increased anxiety, and pain necessitated crisis care. These are not acute symptoms requiring crisis care and do not support Vitas billing Medicare at the higher crisis care rate.

107. Vitas's medical records also state that TS complained of back pain, and that Vitas staff used a heating pad to relieve the pain. The medical record does not indicate that Vitas administered pain medication to TS.

108. Vitas did administer an anti-anxiety drug to TS at a low dose every 4 hours, as needed, during the period that Vitas billed Medicare for crisis care. However, Vitas should have billed Medicare at the routine home care rate for administering this medication.

109. Chemed and Vitas knowingly submitted or caused the submission of a false or fraudulent claim numbered 20609702195205 to Medicare for crisis care services on behalf of patient TS that were not necessary or not provided for the time period March 19, 2006 through March 21, 2006, in the amount of $1037.24; and Medicare paid the claim on April 13, 2006.

b) Crisis Care Billing Period 2

110. Vitas billed Medicare for crisis care for TS for the time period from April 3, 2006 through April 12, 2006.

111. According to Vitas's medical records, beginning on April 3, 2006, Vitas billed Medicare for crisis care for TS's daily wound care, lower extremity edema, and poor nutrition. None of these conditions require crisis care and they should have been addressed through routine home care.

112. A Vitas physician wrote a "crisis care note" on April 8, 2006, stating that crisis care was appropriate for TS at "this time" because she needed "daily dressing changes." Daily dressing changes should be provided and billed as routine home care.

113. Chemed and Vitas knowingly submitted or caused the submission of a false or fraudulent claim numbered 20612502442405 to Medicare for crisis care services on behalf of

patient TS that were not necessary or not provided for the time period April 3, 2006 through April 12, 2006, in the amount of $6839.28; and Medicare paid the claim on May 11, 2006.

c) Crisis Care Billing Period 3

114. Vitas billed Medicare for crisis care for TS for the time period from May 13, 2006 through June 2, 2006.

115. According to Vitas's medical records, it billed Medicare for crisis care for TS for this third time period, beginning on May 13, 2006, for "decreased level of consciousness" after TS had suffered a fall. This did not require crisis care and the patient's condition should have been addressed through routine hospice care.

116. On May 18, 2006, five days after Vitas began billing Medicare for crisis care for TS, the Vitas doctor noted that TS was "nonresponsive," but also wrote that TS was walking.

117. On the following day, May 19, 2006, Vitas changed the reason for TS's crisis care to "safety, pain management, and weakness." "Safety" and "weakness" are not acute symptoms requiring crisis care. Both are chronic medical issues that do not necessitate continuous nursing care. As for the "pain management" that TS required, this should have been addressed through routine home care.

118. In addition, the medical records do not show that Vitas provided care to address TS's pain beyond what would be covered under the routine home care level of hospice care.

119. The care that Vitas did provide to TS to manage her pain, in fact, caused TS's symptoms to become worse. A Vitas nurse noted on May 25, 2006, that the nurse was crushing doses of long-acting morphine before administering them to TS, which prevented the morphine from properly palliating TS's pain. Although there are no indications in TS's medical records that her pain was uncontrolled (and, as stated above, no basis to support Vitas's billing for crisis

care for TS), the nurse's act of crushing long-acting morphine prior to giving it to TS hindered the morphine's effectiveness and caused TS to require additional doses of pain medication. If the reason for crushing the long-acting morphine was because TS had problems swallowing pills, there were several other pain management options (such as liquid methadone) that should have been administered as routine home care and would not have resulted in TS suffering additional pain. Furthermore, the additional doses of pain medication that Vitas administered to TS should have been billed to Medicare as routine home care.

120. Chemed and Vitas knowingly submitted or caused the submission of false or fraudulent claims numbered 20617715080204 and 20621908453304 to Medicare for crisis care services for patient TS that were not necessary, not provided, or inappropriately provided for the time period May 13, 2006 through June 2, 2006, in the amounts of $777.84 and $14422.45; and Medicare paid the claims on June 29, 2006 and August 10, 2006.

iv. Patient DT

121. Chemed and Vitas knowingly submitted or caused to be submitted false or fraudulent claims to Medicare for two separate periods of crisis care for Patient DT, a patient in Pennsylvania, in September and December 2006. These claims were false or fraudulent because Vitas's medical records for patient DT show that DT was not in crisis and because Vitas administered what would be considered routine hospice care, even though Vitas billed Medicare at the higher crisis care rate.

a) Crisis Care Billing Period 1

122. The first period of time for which Vitas billed Medicare for crisis care for DT is for the time period from September 11, 2006 through September 20, 2006.

123. Vitas's medical records do not indicate that DT was in "crisis" requiring nursing care to palliate acute symptoms. The following is shown by Vitas's medical records for DT.

124. The crisis care plan for DT states that DT was having symptoms of weakness, mental status changes, confusion and agitation. Vitas nurses were visiting DT, but intensive nursing care to palliate acute medical symptoms was not necessary or provided. The palliative medications being administered were low-dose and low-frequency, and should have been billed to Medicare as routine home care.

125. Chemed and Vitas knowingly submitted or caused the submission of a false or fraudulent claim numbered 20628201663405 to Medicare for crisis care services for Patient DT that were not necessary or not provided for the time period September 11, 2006 through September 20, 2006, in the amount of $5758.84; and Medicare paid the claim on August 23, 2006.

b) Crisis Care Billing Period 2

126. Vitas also billed Medicare for crisis care for DT for the time period from December 4, 2006 through December 5, 2006. There is nothing in the medical record to show that DT was experiencing acute medical symptoms requiring crisis care during these two days, and again, Vitas did not provide any intensive palliative interventions to DT while it was billing Medicare for crisis care. Vitas should have billed all care provided to DT during this time period as routine home care.

127. Chemed and Vitas knowingly submitted or caused the submission of a false or fraudulent claim numbered 20700401484105 to Medicare for crisis care services for Patient DT that were not necessary or not provided for the time period December 4, 2006 through December 5, 2006, in the amount of $488.14; and Medicare paid the claim on January 18, 2007.

v. Patient RB

128. Chemed and Vitas knowingly submitted or caused to be submitted false or fraudulent claims for crisis care to Medicare for two separate time periods for patient RB in Florida in July 2007 and from June 2009 to July 2009. These claims were false or fraudulent because Vitas's medical records for patient RB show that RB was not in crisis and because Vitas administered what would be considered routine hospice care, even though Vitas billed Medicare at the higher crisis care rate.

a) Crisis Care Billing Period 1

129. The first period of time for which Vitas billed Medicare for crisis care on behalf of RB is for the time period from July 5, 2007 through July 17, 2007.

130. Vitas's medical records for that time period indicate that Vitas began billing Medicare for crisis care on July 5, 2007 in order to address RB's shortness of breath and respiratory distress symptoms. However, on July 6, Vitas noted that RB's symptoms were controlled, she was comfortable, and she was no longer continuing to have labored respirations. Despite this, Vitas continued to bill Medicare for crisis care for RB for an additional eleven days, through July 17, 2007.

131. During these eleven days, RB did not have symptoms that would constitute a crisis, and Vitas only provided RB with medications that should have been billed as routine home care. Even as the medical records indicate that RB stated that she was feeling better and was walking, Vitas continued to bill Medicare for crisis care for RB until July 17, 2007.

132. Chemed and Vitas knowingly submitted or caused the submission of a false or fraudulent claim numbered 20721501536705 to Medicare for crisis care services on behalf of

patient RB that were not necessary or not provided for the time period July 7, 2007 through July 17, 2007, in the approximate amount of $9000; and Medicare paid the claim on August 9, 2007.

b) Crisis Care Billing Period 2

133. Vitas billed Medicare for crisis care for patient RB for a second time period from June 18, 2009 through July 7, 2009. Its medical records state the reasons for crisis care for RB as "change in level of consciousness." However, the nursing notes indicate that RB's consciousness level was normal.

134. During this time period, Vitas administered RB sedative medication, even though RB had a normal level of consciousness, and Vitas documented that RB was alert and verbally responsive, with "periods of forgetfulness," which is not a condition requiring crisis care.

135. Medical records for RB on July 5, 2009, noted that RB was "pleasant and cooperative [and] [c]onsumes 100% meals," but Vitas continued to bill Medicare for crisis care for RB through July 7, 2009.

136. During this entire second time period, totaling twenty days, that Vitas billed Medicare for crisis care for RB, the medical records show no symptoms that would require crisis care to be administered to RB. In fact, RB's needs would have been effectively met by routine hospice care.

137. Chemed and Vitas knowingly submitted or caused the submission of false or fraudulent claims numbered 20919600293705FLR and 20932801614304FLR to Medicare for crisis care services on behalf of patient RB that were not necessary or not provided for the time period June 18, 2009 through July 7, 2009, in the amounts of $10,893.33 and $5523.50; and Medicare paid the claims on July 20, 2009 and December 14, 2009.

vi. Patient MG

138. Chemed and Vitas knowingly submitted or caused to be submitted false or fraudulent claims to Medicare for crisis care for patient MG in California during three separate time periods, from November to December 2009, January to February 2010, and February to March 2010. These claims were false or fraudulent because Vitas's medical records for patient MG show that MG was not in crisis or the care that Vitas provided to MG during this period of time was inappropriate, and Vitas should not have billed Medicare for crisis care.

a) Crisis Care Billing Period 1

139. The first period of time for which Vitas billed Medicare for crisis care for MG is for the time period from November 16, 2009 through December 1, 2009.

140. Vitas's medical records for that time period do not indicate that MG was in "crisis" requiring nursing care to palliate acute medical symptoms. The following is shown by Vitas's medical records.

141. Beginning on November 16, 2009, Vitas's medical records state that the reasons for billing Medicare for crisis care were pain, complicated wound care, and caregiver breakdown. MG's medical records do not indicate that MG's wound care was so complicated as to constitute a crisis requiring billing at the higher rate, and "caregiver breakdown" is not an appropriate basis to bill for crisis care.

142. MG's pain symptoms should have been appropriately managed and billed as routine home care.

143. Vitas did not provide appropriate care to manage MG's pain under any billing rate. Vitas failed to recognize and address MG's symptoms, which caused MG's pain to increase and created additional medical complications for MG. Vitas staff provided MG high intravenous

doses of morphine, which caused MG to suffer from opioid neurotoxicity and opioid hyperalgesia. These conditions, which should have been recognized immediately by Vitas's medical staff, caused MG to experience increasingly greater pain as Vitas administered higher and higher morphine doses.

144. Despite MG exhibiting clear signs and symptoms of opioid neurotoxicity, Vitas staff did not consult a doctor to evaluate MG or to address MG's increasing pain. Instead, Vitas continued to administer higher levels of morphine to MG, which further increased her pain symptoms and caused MG to begin having seizures.

145. Had Vitas staff consulted a doctor regarding MG's pain initially, through routine home care, MG's pain should have been managed effectively, and MG would not have experienced the painful and severe complications of opioid neurotoxicity.

146. Vitas billed Medicare for crisis care for sixteen days during this first period of time, despite the fact that MG's symptoms should have been effectively managed with routine home care, and despite the fact that the "care" provided by Vitas made MG's pain symptoms significantly worse.

147. Chemed and Vitas knowingly submitted or caused the submission of false or fraudulent claims to Medicare for crisis care services on behalf of Patient MG that were not necessary or not provided, or care that was inappropriate, for the time period from November 16, 2009 through December 1, 2009, in the amount of approximately $15,678.64; and Medicare paid the claims.

b) Crisis Care Billing Period 2

148. The second period of time for which Vitas billed Medicare for crisis care for MG is for the time period from January 23, 2010 through February 3, 2010.

149. Vitas billed Medicare for crisis care for MG starting on January 23, 2010, and this time the medical records stated that seizures were the basis for crisis care. As discussed above, MG's earlier seizures were a direct result of Vitas administering high intravenous doses of morphine to MG and failing to adequately address MG's pain symptoms. During this time period, totaling eleven days, Vitas changed MG's medicine to dilaudid from morphine, and on January 31, 2010 noted that MG began to improve. Despite this improvement, Vitas continued to bill for crisis care for MG for an additional 3 days, until February 3, 2010, even though Vitas should have provided services to MG as routine home care.

150. Chemed and Vitas knowingly submitted or caused the submission of false or fraudulent claims to Medicare for crisis care services to Patient MG that were not necessary or not provided, or care that was inappropriate, for the time period January 23, 2010 through February 3, 2010, in the amount of approximately $10,531.31; and Medicare paid the claims.

c) Crisis Care Billing Period 3

151. The third period of time for which Vitas billed Medicare for crisis care is for the time period from February 19, 2010 through March 8, 2010.

152. According to its medical records, Vitas billed Medicare for crisis care for MG beginning on February 25, 2010, and ending on March 8, 2010, for the stated reason of "seizures." However, Vitas's records do not indicate that MG suffered seizures during this time period. MG was not otherwise in "crisis" during this time period. Vitas should not have billed Medicare for crisis care when routine home care was appropriate.

153. Chemed and Vitas knowingly submitted or caused the submission of false or fraudulent claims to Medicare for crisis care services to Patient MG that were not necessary or

not provided for the time period February 25, 2010 through March 8, 2010, in the amount of approximately $5,000; and Medicare paid the claims.

vii. Patient FA

154. Chemed and Vitas knowingly submitted or caused to be submitted false or fraudulent claims to Medicare for eight days of crisis care for patient FA, an Alzheimer's patient in Texas, in November 2007. These claims were false or fraudulent because Vitas's medical records for patient FA show that FA was not in crisis and because Vitas administered what would be considered routine home care, even though Vitas billed Medicare at the higher crisis care rate.

155. Vitas's medical records for FA do not indicate that FA was experiencing a medical "crisis" that required nursing care to palliate acute symptoms.

156. On November 23, 2007, the same date that Vitas began billing Medicare for crisis care for what Vitas referred to as "decreased level of consciousness and tachypnea," Vitas's records show that Vitas actually offered crisis care to FA and his family because FA's family was considering aggressive curative therapy instead of continuing hospice care. Thus, Vitas was using crisis care as a way to keep FA on hospice care so that it could continue to bill Medicare on behalf of FA, not to palliate any acute medical symptoms.

157. During the billing period, all of FA's symptoms were managed through the administration of services that should have been provided under routine home care.

158. Chemed and Vitas knowingly submitted or caused the submission of false or fraudulent claims to Medicare for crisis care services on behalf of Patient FA that were not necessary or not provided for the time period November 23, 2007 through November 30, 2007, in the amount of approximately $5257; and Medicare paid the claims.

VII. Chemed and Vitas Submitted or Caused to be Submitted False and Fraudulent Claims for Patients Who Did Not Meet the Medical Criteria for End of Life Care.

159. Chemed and Vitas knowingly submitted or caused to be submitted false or fraudulent claims to Medicare for patients who were not "terminally ill" with a prognosis of six months or less if their illness ran its normal course and, therefore, were not eligible to receive end of life care. Chemed and Vitas also created, submitted, or caused to be submitted documentation that falsely represented that certain Medicare patients were eligible for hospice when they were not.

A. Chemed's and Vitas's Business Practices Led to the Submission of False or Fraudulent Claims for Ineligible Patients

160. Vitas's business practices led to the submission of false claims for patients who did not need end of life care. Top-level managers at Vitas's corporate headquarters set aggressive hospice admissions goals for regional and mid-level corporate managers at local Vitas programs, resulting in the admission of ineligible patients.

161. Chemed management regularly corresponded with Vitas management about the average daily census and growth in admissions, making focused frequent inquiries if they believed the numbers reported were too low.

162. Vitas senior managers regularly corresponded with personnel in the field offices when their average daily census and admissions growth were lagging.

163. Chemed and Vitas falsely certified on electronic claim forms that they submitted (or caused to be submitted) to Medicare that Vitas's claims were "correct and complete" and that Vitas maintained patient medical records in compliance with the certification requirements of 42 C.F.R. § 418.22.

164. Vitas's corporate culture encouraged its marketing and clinical staff to admit as many patients as possible, regardless of whether they were eligible for hospice.

165. The general manager of each Vitas program was directly evaluated on the profitability and the number of patients admitted at that program's facility.

166. General managers, who were typically not nurses or doctors, expected their marketing departments and sales representatives to find referral sources and patients, and evaluated and promoted their employees based on meeting hospice admissions goals. This often meant that the Vitas program managers disregarded concerns of nurses and doctors who expressed that they did not believe that certain Vitas hospice patients were terminally ill.

167. Vitas paid bonuses to its non-clinical staff based on the number of patients enrolled into the program.

168. Vitas took adverse employment actions against marketing representatives who did not meet monthly admissions goals. One former general manager stated that Vitas paid him bonuses based on the number of patient admissions and the length of time he could get a patient to stay on hospice services.

169. Vitas did not properly train its staff on hospice eligibility criteria. One former Vitas medical director stated that he received no training at all from Vitas on Medicare eligibility requirements for hospice, and that Vitas expected him to certify patients as eligible for hospice without making actual determinations that the patient had a prognosis of six months or less if their illness ran its normal course. In contrast, numerous Vitas marketing employees said that Vitas spent a significant amount of resources training its marketing employees on how to "sell hospice" to patients, patients' families, and referral sources for potential hospice patients.

170. Vitas also employed field nurses to provide care to its hospice patients residing in skilled nursing facilities, assisted living facilities, and hospitals, but did not provide them adequate training on the eligibility requirements for the Medicare hospice benefit.

171. Vitas directed these untrained field nurses, as part of their job duties, to identify elderly people who were eligible for the Medicare hospice benefit, and to encourage the referral of elderly people to Vitas for end of life care.

172. According to one former hospice manager for Vitas, the company philosophy was to "sign everybody up" for Medicare hospice services. A former Vitas nurse in Florida said that Vitas "wanted everyone enrolled in hospice care." This philosophy is inconsistent with Medicare requirements, because, for example, a patient who elects hospice care under the Medicare program also chooses to stop receiving curative care for his or her illness.

173. Medical staff reported that they felt pressured by Vitas to admit or readmit patients who were inappropriate for hospice services. One former Vitas admissions nurse said that if he did not admit a patient he believed to be ineligible, he would be pressured to reconsider his decision until he finally determined the patient was eligible for the Medicare hospice benefit. The same nurse stated that he was pressured by Vitas to bend the Medicare rules to get patients onto hospice service.

174. Another Vitas nurse stated that when she attended the weekly meetings to discuss discharging patients, the goal was to discharge as few patients as possible without regard to hospice appropriateness. Discharging more than four patients per meeting was frowned upon by the Vitas business managers, and Vitas medical staff were told to stop discharging patients even if patients were not eligible.

175. The same Vitas nurse stated that she was instructed by Vitas to falsely write that a patient experienced symptoms that the patient did not experience in order to support a determination of hospice eligibility. For example, she was once told to write that a patient had

an unnatural color, or pallor, when the patient did not, and was instructed not to write that the patient's health was improving in the medical record.

176. One Vitas team doctor stated that on several occasions, when he did not believe patients were eligible for hospice, and therefore did not certify the patients as eligible, the Vitas medical director overruled him and signed the certification even in the absence of justification.

177. A former Vitas physician stated that he was under pressure from Vitas management to increase the number of patients admitted to hospice, and that he was often overruled when he determined that a patient should be discharged because the patient was not dying. This physician informed Vitas managers that he was concerned that his medical decisions were being ignored, but Vitas did not address his concerns.

178. At least beginning in 2007, Chemed and Vitas were aware that ineligible patients were regularly being admitted in their San Antonio, Texas location.

179. The Medical Director in the San Antonio location, who was employed by Vitas from approximately 1998-2008, regularly admitted Medicare beneficiaries to hospice with little regard as to their eligibility for hospice under the Medicare regulations.

180. In 2007, the San Antonio location was the focus of a medical review by its Medicare claims processor, Palmetto, to determine whether Vitas was submitting claims for ineligible patients.

181. As a result of this medical review, several of Vitas's medical directors conducted their own internal limited review to determine whether certain patients they had admitted to hospice care were ineligible. As a result of the review, Vitas discharged 75-80 patients because it determined they were not eligible for hospice services because they did not have a life expectancy of six months or less.

182. Vitas did not repay the Medicare care program for these ineligible patients; and neither Vitas nor Chemed conducted a broader investigation.

183. During the review, at least one hospice physician at the San Antonio location informed Vitas's Vice-President of Operations that the former medical director for the San Antonio facility, who was employed from 1998 to 2008, had knowingly admitted and recertified patients who did not meet Medicare's hospice eligibility requirements.

184. Neither Vitas nor Chemed conducted a broader investigation in response to the disclosure made by this San Antonio physician.

185. As shown in the below specific patient examples, Vitas's own patient medical records do not support a medical prognosis that the patient's life expectancy was six months or less if the illness ran its normal course.

B. Examples of False Claims for Ineligible Patients[2]

186. Chemed and Vitas knowingly submitted or caused to be submitted to Medicare numerous false or fraudulent claims for Medicare reimbursement for patients who did not need end of life care because they did not have a medical prognosis of six months or less if their illnesses ran the normal course.

i. Patient MP

187. Chemed and Vitas knowingly submitted or caused to be submitted false or fraudulent claims to Medicare for hospice care for Patient MP in Missouri from April 10, 2009 through February 3, 2010. These claims were false or fraudulent because Vitas's medical

[2] To protect patient privacy, the United States has not identified by name the individuals who are examples of patients whom Vitas knew were not eligible for hospice care though it continued to bill Medicare. The United States will serve Vitas with a list identifying each patient by name and patient identification number.

records for MP show that MP did not have a terminal illness with a prognosis of six months or less if MP's disease ran its normal course.

188. According to Vitas's medical records, Vitas admitted MP to hospice based upon a diagnosis of debility, but MP did not meet the medical criteria for this diagnosis. In addition, on April 10, 2009, the day MP was admitted to hospice, there was no indication that MP's pre-existing condition had deteriorated. The medical records state that MP was alert and "oriented to self, denied pain," and weighed 151 pounds, having only lost two pounds in the last one to two months.

189. Throughout the period that Medicare paid Vitas's claims on behalf of MP, Vitas's medical records show that MP remained stable and even gained weight, and her body mass index remained consistently above the level required by hospice eligibility criteria.

190. Chemed and Vitas knowingly submitted or caused the submission of false or fraudulent claims to Medicare for hospice care on behalf of patient MP from April 10, 2009 through February 3, 2010, in the amount of $42,763.82; and Medicare paid the claims.

ii. Patient WB

191. Chemed and Vitas knowingly submitted or caused to be submitted false or fraudulent claims to Medicare for hospice care on behalf of Patient WB in California, covering the period from June 5, 2008 through March 18, 2011. These claims were false or fraudulent because Vitas's medical records for WB show that WB did not have a terminal illness with a prognosis of six months or less if WB's illness ran its normal course.

192. Vitas's medical records for WB also show that at each period of time when Vitas recertified that WB was eligible for hospice care, WB did not have a terminal illness with a prognosis of six months or less if WB's illness ran its normal course.

193. According to Vitas's medical records, Vitas admitted WB to hospice based upon a diagnosis of "cardiovascular disease," but there were no medical examination findings to support the conclusion that WB was in end-stage heart failure or had another end-stage cardiac condition, and Vitas did not accurately assess whether WB had a terminal illness with a prognosis of six months or less if WB's illness ran its normal course.

194. A patient with a cardiac disease can be terminal if the patient meets the criteria for "Class IV" on the New York Heart Association's system for classifying degrees of heart failure. To be "Class IV," a patient must be unable to carry out any physical activity without discomfort, have symptoms of cardiac insufficiency while at rest, and experience increased discomfort if the patient engages in any physical activity.

195. Vitas's records for WB show that he had no shortness of breath or other heart failure symptoms while at rest. Additionally, Vitas gradually decreased the heart medications that WB received while he was on hospice care, finally ceasing all of WB's heart medicines on December 20, 2009. Throughout his time on hospice, WB remained stable and was clearly not suffering from end-stage heart disease.

196. Vitas's medical records for WB contained inconsistent and contradictory information, including inconsistent descriptions of WB's symptoms written by different members of Vitas staff as well as inaccurate functional scores noted by Vitas staff but contradicted by WB's documented symptoms. For example, nursing notes in WB's medical files would state that WB had no shortness of breath, but a doctor who visited WB around the same time wrote that WB had intermittent shortness of breath. Additionally, Vitas staff noted in WB's records that he was experiencing "slow progressive decline" and "remain[ed] appropriate for hospice with prognosis of 6 [months] or less," Vitas's records for WB lack any

documentation of decline in WB's nutritional or functional status, or other factors that would indicate that WB had a prognosis of six months or less if his disease ran its normal course.

197. After remaining stable while he received hospice care for almost three years, WB was ultimately discharged from hospice on March 2, 2011 for extended prognosis.

198. Chemed and Vitas knowingly submitted or caused the submission of false or fraudulent claims to Medicare for hospice care on behalf of Patient WB from June 5, 2008 through March 18, 2011, in the amount of $170,666.02; and Medicare paid the claims.

iii. Patient MC

199. Chemed and Vitas knowingly submitted or caused to be submitted false and fraudulent claims for hospice care on behalf of Patient MC in California, covering the period from July 18, 2009 through February 16, 2012. These claims were false or fraudulent because Vitas's medical records for MC show that MC did not have a terminal illness with a prognosis of six months or less if MP's disease ran its normal course.

200. Vitas's medical records for MC also show that at each period of time when Vitas recertified that MC was eligible for hospice care, MC did not have a terminal illness with a prognosis of six months or less if MC's illness ran its normal course.

201. According to Vitas's medical records, Vitas admitted MC to hospice after a hospital stay, based upon a diagnosis of "heart failure," but MC had no symptoms to indicate MC had any end-stage disease or condition, including heart disease. At the time of MC's admission to the hospital, MC was living independently and performing daily activities without assistance.

202. At around the time Vitas admitted MC to its hospice program, its medical notes for MC stated that MC was "very healthy given her age." In fact, Vitas stopped administering MC heart medications during her time in hospice.

203. During MC's hospice stay, the only medications that Vitas administered were for anxiety. MC was walking and performing daily activities without assistance.

204. In March 2010, a doctor noted that MC did not need oxygen, unless she became excited. Any shortness of breath was related to MC's anxiety, not heart disease.

205. In addition to improperly admitting MC for hospice care when she was not eligible, Chemed and Vitas also knowingly submitted or caused to be submitted false or fraudulent claims to Medicare on behalf of MC for crisis care.

206. On January 20, 2012, Vitas began billing Medicare for crisis care for MC due to "caregiver teaching and breakdown," neither of which are bases to submit claims to Medicare for crisis care.

207. During the time that Vitas billed Medicare for crisis care for MC, Vitas's nursing notes state that MC was doing her own laundry. Vitas stopped billing Medicare for crisis care on January 24, 2012 for unspecified reasons.

208. MC died on February 16, 2012, after being on hospice for approximately two and a half years. Although MC died while receiving hospice, at no point during the time that Vitas billed Medicare for MC's hospice care did MC have a life expectancy of six months or less if a disease ran its normal course.

209. Chemed and Vitas knowingly submitted or caused the submission of false or fraudulent claims to Medicare for hospice care on behalf of Patient MC from July 18, 2009 through February 16, 2012, in the amount of approximately $169,820.99 and Medicare paid the claims.

iv. Patient FA

210. Chemed and Vitas knowingly submitted or caused to be submitted false or fraudulent claims for hospice care on behalf of Patient FA in Texas covering the period from May 1, 2005 through April 26, 2006. These claims were false or fraudulent because Vitas's medical records for patient FA show that FA did not have a terminal illness with a prognosis of six months or less if FA's disease ran its normal course.

211. It is unclear from Vitas's medical records whether it admitted FA to hospice based upon a diagnosis of dementia, debility, or Alzheimer's disease. Nonetheless, FA did not meet the hospice eligibility criteria for dementia, debility, or Alzheimer's disease at any point during FA's hospice stay.

212. At the time of admission, FA's body mass index was 31.6, which did not meet the nutritional eligibility criteria for debility. Additionally, Vitas's records state that FA was ambulatory and walking, and therefore FA did not meet the Palliative Performance Scale criteria for eligibility for hospice for a debility diagnosis.

213. FA also did not meet the eligibility criteria for Alzheimer's disease. Vitas's staff documented that FA was answering questions, and therefore did not have the functional impairment required to meet eligibility criteria for Alzheimer's disease.

214. On February 14, 2006, a Vitas nurse wrote that she had asked a physician to evaluate FA's eligibility for hospice, and that she had already notified FA's family and facility staff of FA's potential discharge from hospice. Despite this, the Vitas physician certified FA for hospice again, even while documenting that FA was answering simple questions and was walking.

215. FA's family revoked the hospice benefit on February 24, 2006, and FA was discharged from hospice.

216. Chemed and Vitas knowingly submitted or caused the submission of false or fraudulent claims to Medicare for hospice care on behalf of Patient FA from May 1, 2005 through April 26, 2006, in the amount of approximately $35,000; and Medicare paid the claims.

v. Patient EC

217. Chemed and Vitas knowingly submitted or caused to be submitted false or fraudulent claims for hospice care on behalf of patient EC in Texas covering the period from April 28, 2006 through December 15, 2007. These claims were false or fraudulent because Vitas's medical records for patient EC show that EC did not have a terminal illness with a prognosis of six months or less if EC's disease ran its normal course.

218. Vitas admitted EC to hospice for end stage congestive heart failure, but Vitas's medical records did not support this diagnosis at any point during the period that EC received hospice services.

219. When EC was admitted to hospice in April 2006, the admitting physician noted that EC showed no evidence of heart failure after a medical examination, and wrote in EC's medical records that he questioned whether EC had heart failure.

220. A patient with a cardiac disease can be terminal if the patient meets the criteria for "Class IV" on the New York Heart Association's system for classifying degrees of heart failure. To be "Class IV," a patient must be unable to carry out any physical activity without discomfort, have symptoms of cardiac insufficiency while at rest, and experience increased discomfort if the patient engages in any physical activity. EC was a Class II, which is not hospice eligible.

221. In July 2006, when Vitas was providing EC hospice care, EC could perform daily activities without assistance. Also, on May 2, 2007, EC was fishing when Vitas was billing Medicare.

222. Chemed and Vitas knowingly submitted or caused the submission of false or fraudulent claims to Medicare for hospice care for Patient EC from April 28, 2006 through December 15, 2007, in the amount of approximately $111,378.00; and Medicare paid the claims.

vi. Patient JD

223. Chemed and Vitas knowingly submitted or caused to be submitted false or fraudulent claims for hospice care on behalf of patient JD in Texas covering the period from February 21, 2006 through June 30, 2008. These claims were false or fraudulent because Vitas's medical records for JD show that JD did not have a terminal illness with a prognosis of six months or less if JD's disease ran its normal course.

224. JD suffered a significant heart attack, was hospitalized, and then was admitted to hospice in February 2006, even though when JD was discharged from the hospital his heart conditions were documented as being under control. In fact, when JD began receiving hospice care at home, he was no longer taking heart medication, and Vitas staff had noted that his functional status was good.

225. According to Vitas's medical records, Vitas admitted JD to hospice based upon a diagnosis of end stage heart failure.

226. A patient with a cardiac disease can be terminal if the patient meets the criteria for "Class IV" on the New York Heart Association's system for classifying degrees of heart failure. To be "Class IV," a patient must be unable to carry out any physical activity without discomfort, have symptoms of cardiac insufficiency while at rest, and experience increased discomfort if the

patient engages in any physical activity. JD did not meet the medical conditions for this classification.

227. During the time when Vitas was billing Medicare on behalf of JD, Vitas's medical records show that JD did not experience shortness of breath while at rest. Additionally, on May 8, 2007, a Vitas physician wrote that JD was ambulating well and driving.

228. On August 10, 2007, a physician noted that JD did not have chest pain, was not on heart medication and that his heart was well compensated and stable.

229. In November 2007, JD voluntarily revoked hospice.

230. Vitas readmitted JD to hospice two months later. Vitas's medical records show that JD was experiencing shortness of breath, but it was unrelated to heart disease.

231. Vitas continued to submit claims to Medicare on behalf of JD until June 25, 2008 when he was discharged from hospice for having an extended prognosis.

232. Chemed and Vitas knowingly submitted or caused the submission of false or fraudulent claims to Medicare for hospice care on behalf of Patient JD from February 21, 2006 through June 30, 2008, in the amount of approximately $80,000; and Medicare paid the claims.

vii. Patient LH

233. Chemed and Vitas knowingly submitted or caused to be submitted false or fraudulent claims for hospice care for patient LH in Texas covering the period from January 23, 2006 through August 10, 2007. These claims were false or fraudulent because Vitas's medical records for LH show that LH did not have a terminal illness with a prognosis of six months or less if LH's disease ran its normal course.

234. Vitas's medical records for LH also show that at each period of time when Vitas recertified that LH was eligible for hospice care, LH did not have a terminal illness with a prognosis of six months or less if LH's illness ran its normal course.

235. According to Vitas's medical records, Vitas admitted LH to hospice based upon a diagnosis of debility and organic brain syndrome (or dementia).

236. LH did not meet eligibility criteria for hospice for debility, dementia, or Alzheimer's during any period of time when Vitas billed Medicare for LH's hospice care. LH was engaging in daily living activities, speaking in full sentences, and showed nutritional improvement.

237. A dementia patient may be eligible for hospice if he or she has a Functional Assessment Staging Test score (also called "FAST score") of 7, meaning that the dementia is severe and end stage. Vitas's medical records for LH clearly indicate that she did not have a FAST score of 7. Additionally, LH was not eligible for hospice under any other diagnoses, including Alzheimer's or debility.

238. LH was speaking in full sentences at the time of admission and could perform all activities of daily living, including walking. Vitas's staff improperly identified LH as having a FAST score of 7(b), which was wrong. Vitas's records state that LH was stable and gaining weight, and that LH did not meet the nutritional or functional requirements for hospice eligibility at any point during her hospice stay.

239. In May 2007, a nurse wrote in the medical records that LH's weight was stable and that she was answering questions appropriately. At that time her body mass index was 23, which is higher than the eligibility criteria of 22 or lower.

240. LH was discharged from hospice on August 10, 2007, for having an extended prognosis.

241. Chemed and Vitas knowingly submitted or caused the submission of false or fraudulent claims to Medicare for hospice care for Patient LH from January 23, 2006 through August 10, 2007, in the amount of $69,418.60; and Medicare paid the claims.

FIRST CAUSE OF ACTION
(False or Fraudulent Claims)
(False Claims Act-31 U.S.C. § 3729(a)(1)(A)),
formerly 31 U.S.C. § 3729(a)(1)).

242. The United States re-alleges and incorporates by reference the allegations of paragraphs 1 through 241.

243. By virtue of the acts described above, Chemed and Vitas knowingly presented or caused to be presented to an officer or employee of the United States false or fraudulent Medicare claims for payment or approval, in violation of the False Claims Act, 31 U.S.C. § 3729(a)(1), amended by 31 U.S.C. § 3729(a)(1)(A); that is, Chemed and Vitas knowingly made or presented, or caused to be made or presented, to the United States claims for payment for hospice services for patients who were not eligible in whole or part for Medicare hospice benefits, and for medically unnecessary services or services that were not provided or were inappropriate.

244. By reason of the foregoing, the United States suffered actual damages in an amount to be determined at trial; and therefore is entitled to treble damages under the False Claims Act, plus civil penalties of not less than $5,500 and not more than $11,000 per false claim. Pursuant to the Federal Civil Penalties Inflation Adjustment Act of 1990, as amended by the Debt Collection Improvement Act of 1996, 28 U.S.C. § 2461 (notes), and 64 Fed. Reg.

47099, 47103 (1999), civil penalties were adjusted to $5,500 to $11,000 for violations occurring on or after September 29, 1999.

SECOND CAUSE OF ACTION
(False Statements)
(False Claims Act-31 U.S.C. § 3729(a)(1)(B), formerly 31 U.S.C. § 3729(a)(2))

245. The United States re-alleges and incorporates by reference the allegations of paragraphs 1 through 241.

246. By virtue of the acts described above, Chemed and Vitas knowingly made, used, or caused to be used a false record or statement material to a false or fraudulent Medicare claim, in violation of the False Claims Act, 31 U.S.C. § 3729(a)(2), amended by 31 U.S.C. § 3729(a)(1)(B).

247. By reason of the foregoing, the United States suffered actual damages in an amount to be determined at trial; and therefore is entitled to treble damages under the False Claims Act, plus civil penalties of not less than $5,500 and not more than $11,000 per false claim. Pursuant to the Federal Civil Penalties Inflation Adjustment Act of 1990, as amended by the Debt Collection Improvement Act of 1996, 28 U.S.C. § 2461 (notes), and 64 Fed. Reg. 47099, 47103 (1999), the civil penalties were adjusted to $5,500 to $11,000 for violations occurring on or after September 29, 1999.

THIRD CAUSE OF ACTION
(Payment by Mistake)

248. The United States re-alleges and incorporates by reference the allegations of paragraphs 1 through 241.

249. This is a claim by the United States for the recovery of monies paid to Chemed and Vitas by mistake for ineligible Medicare beneficiaries and for Medicare services that were medically unnecessary, or not appropriate.

250. As a consequence of the conduct and the acts set forth above, Chemed and Vitas were paid by mistake by the United States in an amount to be determined which, under the circumstances, in equity and good conscience, should be returned to the United States.

FOURTH CAUSE OF ACTION
(Unjust Enrichment)

251. The United States re-alleges and incorporates by reference the allegations of paragraphs 1 through 241.

252. This is a claim by the United States for recovery of monies by which Chemed and Vitas have been unjustly enriched.

253. By virtue of the conduct and the acts described above, Chemed and Vitas were unjustly enriched at the expense of the United States in an amount to be determined, which, under the circumstances, in equity and good conscience, should be returned to the United States.

PRAYER FOR RELIEF AND JURY DEMAND

WHEREFORE, the United States respectfully prays for judgment in its favor as follows:

a. As to First and Second Causes of Action (False Claims Act), against Chemed and Vitas for: (i) statutory damages in an amount to be established at trial, trebled as required by law, and such penalties as are required by law; (ii) the costs of this action, plus interest, as provided by law; and (iii) any other relief that this Court deems appropriate, to be determined at a trial by jury.

b. As to the Third Cause of Action (Payment Under Mistake of Fact), for: (i) an amount equal to the money paid by the United States through the Medicare

Program to Chemed or Vitas, and illegally retained by Chemed or Vitas, plus interest; (ii) the costs of this action, plus interest, as provided by law; and (iii) any other relief that this Court deems appropriate, to be determined at a trial by jury.

c. As to the Fourth Cause of Action (Unjust Enrichment), for: (i) an amount equal to the money paid by the United States through the Medicare Program to Chemed and Vitas, or the amount by which Chemed and Vitas were unjustly enriched, plus interest; (ii) the costs of this action, plus interest, as provided by law; and (iii) any other relief that this Court deems appropriate, to be determined at a trial by jury.

d. And for all other and further relief as the Court may deem just and proper.

The United States hereby demands a jury trial on all claims alleged herein.

Respectfully submitted this the 2nd day of May, 2013.

STUART F. DELERY
ACTING ASSISTANT ATTORNEY GENERAL

Tammy Dickinson
United States Attorney

By: ***/s/ Lucinda S. Woolery***

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JS 44 (Rev 09/10)

UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF MISSOURI

CIVIL COVER SHEET

This automated JS-44 conforms generally to the manual JS-44 approved by the Judicial Conference of the United States in September 1974. The data is required for the use of the Clerk of Court for the purpose of initiating the civil docket sheet. The information contained herein neither replaces nor supplements the filing and service of pleadings or other papers as required by law. This form is authorized for use only in the Western District of Missouri.

The completed cover sheet must be saved as a pdf document and filed as an attachment to the Complaint or Notice of Removal.

Plaintiff(s):

First Listed Plaintiff:
United States of America ;
County of Residence: Jackson County

Defendant(s):

First Listed Defendant:
VITAS Hospice Services, L.L.C. ;
County of Residence: Jackson County

Additional Defendants(s):
VITAS Healthcare Corporation ;
VITAS Care Solutions, Inc. ;
VITAS Healthcare Corporation of California ;
VITAS Healthcare Corporation of Illinois ;
VITAS Healthcare Corporation of Florida ;
VITAS Healthcare Corporation of Ohio ;
VITAS Healthcare Corporation of Atlantic ;
VITAS Healthcare of Texas, L.P. ;
VITAS Healthcare Corporation Midwest ;
VITAS Healthcare Corporation of Georgia ;
VITAS HME Solutions, Inc. ;
VITAS of North Florida ;
VITAS Holdings Corporation ;
VITAS RT, Inc. ;
VITAS Solutions, Inc. ;
Hospice Care Inc. ;
Chemed Corporation ;
Comfort Care Holdings Co. ;

County Where Claim For Relief Arose: Jackson County

Plaintiff's Attorney(s):

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Defendant's Attorney(s):

Basis of Jurisdiction: 1. U.S. Government Plaintiff

Citizenship of Principal Parties (Diversity Cases Only)

Plaintiff: N/A

Defendant: N/A

Origin: 1. Original Proceeding

Nature of Suit: 375 False Claims Act (31 U.S.C. 3729)
Cause of Action: 31 U.S.C. § 3729, et seq. False Claims Act
Requested in Complaint

Class Action: Not filed as a Class Action

Monetary Demand (in Thousands): Unspecified Damages

Jury Demand: Yes

Related Cases: Is NOT a refiling of a previously dismissed action

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Signature: /s/ Lucinda S. Woolery

Date: 05/02/13

If any of this information is incorrect, please close this window and go back to the Civil Cover Sheet Input form to make the correction and generate the updated JS44. Once corrected, print this form, sign and date it, and submit it with your new civil action.

Exhibit B

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF OHIO
WESTERN DIVISION

In re CHEMED CORP. SECURITIES LITIGATION	No. 1:12-cv-00028-MRB

JUDGMENT

On the ___day of _____, 2014, a hearing having been held before this Court to determine: (1) whether the terms and conditions of the Stipulation and Agreement of Settlement dated February 6, 2014, (the "Stipulation") are fair, reasonable, and adequate for the settlement of claims asserted by the Settlement Class against the Defendants in the Action, and in the Second Amended Complaint, dated February 6, 2014 (the "Complaint"), now pending in this Court under the above caption, and should be approved; (2) whether judgment should be entered dismissing the Complaint and all Settled Claims against Defendants and the Releasees, on the merits and with prejudice in favor of the Defendants and Releasees and as against all persons or entities who are members of the Settlement Class herein who have not requested exclusion therefrom; (3) whether to approve the Plan of Allocation as a fair and reasonable method to allocate the settlement proceeds among the members of the Settlement Class; and (4) whether and in what amount to award Co-Lead Counsel fees and expenses. The Court having considered all matters submitted to it at the hearing and otherwise; and it appearing that a notice of the hearing substantially in the form approved by the Court was mailed to all persons or entities reasonably identifiable, as shown by the records of Chemed's transfer agent and others, at the respective addresses set forth in such records, who purchased the capital stock of Chemed

Corporation ("Chemed") during the period February 15, 2010 through May 2, 2013, inclusive (the "Class Period"), except those persons or entities excluded from the definition of the Settlement Class, and that a summary notice of the hearing substantially in the form approved by the Court was published in *Investor's Business Daily* and transmitted over the *Business Wire* pursuant to the specifications of the Court; and all capitalized terms used herein having the meanings as set forth and defined in the Stipulation.

NOW, THEREFORE, IT IS HEREBY ORDERED THAT:

1. The Court has jurisdiction over the subject matter of the Action, the Lead Plaintiffs, all Settlement Class Members and Defendants.

2. The Court finds that the prerequisites for a class action under Federal Rules of Civil Procedure 23(a) and (b)(3) have been satisfied in that: (i) the number of Settlement Class Members is so numerous that joinder of all members thereof is impracticable; (ii) there are questions of law and fact common to the Settlement Class; (iii) the claims of the proposed Class Representatives are typical of the claims of the Settlement Class they seek to represent; (iv) the proposed Class Representatives and Class Counsel have and will adequately represent the interests of the Settlement Class; (v) the questions of law and fact common to the members of the Settlement Class predominate over any questions affecting only individual members of the Settlement Class; and (vi) a class action is superior to other available methods for the fair and efficient adjudication of the controversy.

3. Pursuant to Rule 23 of the Federal Rules of Civil Procedure, this Court hereby finally certifies this Action as a class action on behalf of all persons or entities that purchased or otherwise acquired the capital stock of Chemed during the Class Period, February 15, 2010 through May 2, 2013, inclusive, and who were damaged thereby (the "Settlement Class").

Excluded from the Settlement Class are: (i) Defendants; (ii) the officers and directors of Chemed, at any point during the Class Period; (iii) members of the immediate family of each of the Individual Defendants and the officers and directors of Chemed, at any point during the Class Period; (iv) any entity in which Defendants have or had a controlling interest; and (v) the legal representatives, heirs, predecessors, successors or assigns of any such excluded party. [Also excluded from the Settlement Class are the persons and/or entities who timely and validly requested exclusion from the Settlement Class as listed on Exhibit 1 annexed hereto OR No valid requests for exclusion from the Settlement Class were received.]

4. Pursuant to Rule 23 of the Federal Rules of Civil Procedure, this Court hereby finally certifies Lead Plaintiffs Electrical Workers Pension Fund, Local 103, I.B.E.W., and Greater Pennsylvania Carpenters Pension Fund as Class Representatives and Co-Lead Counsel Labaton Sucharow LLP and Robbins Geller Rudman & Dowd LLP are certified as Class Counsel.

5. Notice of the pendency of this Action as a class action and of the proposed Settlement was given to all Settlement Class Members who could be identified with reasonable effort. The form and method of notifying the Settlement Class of the pendency of the Action as a class action and of the terms and conditions of the proposed Settlement met the requirements of Rule 23 of the Federal Rules of Civil Procedure, Section 21D(a)(7) of the Securities Exchange Act of 1934, 15 U.S.C. § 78u-4(a)(7) as amended by the Private Securities Litigation Reform Act of 1995 (the "PSLRA"), due process, and any other applicable law, constituted the best notice practicable under the circumstances, and constituted due and sufficient notice to all persons and entities entitled thereto. Class Counsel has filed with the Court proof of mailing of the Notice and Proof of Claim and proof of publication of the Publication Notice.

6. The Settlement is approved as fair, reasonable, and adequate, and the Settlement Class Members and the Settling Parties are directed to consummate the Settlement in accordance with the terms and provisions of the Stipulation.

7. The Complaint is hereby dismissed with prejudice and without costs, except as provided in the Stipulation, as against the Defendants.

8. Upon the Effective Date of the Settlement, Lead Plaintiffs and all the other members of the Settlement Class, on behalf of themselves, and jointly and severally, individually and collectively, their past, present and future direct and indirect parents, subsidiaries, divisions and affiliates, and their respective present and former officers, directors, employees, managers, agents, attorneys and legal representatives, and the predecessors, successors, heirs, executors, trustees, administrators and assigns of each of the foregoing (the "Releasors"[1]) have released and discharged, and are hereby permanently barred and enjoined from initiating, continuing, filing, or otherwise prosecuting any and all claims (including any claim that the Stipulation was fraudulently induced), debts, demands, rights, actions, suits, causes of action or liabilities whatsoever (including, but not limited to, any and all claims for damages, interest, attorneys' fees, expert or consulting fees, and any other costs, expenses or liability whatsoever), whether based on federal, state, local, statutory, or common law, or any other law, rule or regulation (whether foreign or domestic), whether class or individual in nature, including both known claims and Unknown Claims, (i) that have been asserted in this Action by or on behalf of the Settlement Class Members or any of them against any of the Releasees (including without limitation all claims and allegations in the Complaint, the Amended Complaint and/or the

[1] As used with respect to Releasors, "affiliates" means entities controlling, controlled by or under common control with Releasors.

Second Amended Complaint), or (ii) that could have been asserted in any forum by or on behalf of the Releasors now or in the future, or any of them, against any of the Releasees or Defendants' Counsel that relate to, or that in any way arise out of, or are based upon, the allegations, transactions, facts, matters or occurrences, acts, disclosures, statements, representations, omissions, or failures to act involved, set forth, or referred to in any of the complaints or proposed complaints filed in this Action, including but not limited to the Complaint, the Amended Complaint and/or the Second Amended Complaint, and that relate to the purchase, acquisition, or sale of the capital stock of Chemed during the Class Period (the "Settled Claims")[2] against, jointly and severally, individually and collectively, the Individual Defendants, Chemed, and its past, present, and future direct and indirect parents, subsidiaries, divisions and affiliates, and their respective present and former officers, directors, employees, managers, agents, insurers, attorneys and legal representatives, and the predecessors, successors, heirs, executors, trustees, administrators and assigns of each of the foregoing (the "Releasees"[3]). Upon the Effective Date, the Settled Claims of all the Releasors are compromised, settled, released, discharged, and dismissed as against the Releasees on the merits and with prejudice by virtue of the proceedings herein and this Judgment.

9. Pursuant to the PSLRA, upon the Effective Date of the Settlement, the Releasees are discharged from all claims for contribution by any person or entity, whether arising under

[2] Settled Claims do not include: (i) claims to enforce the Settlement; (ii) *KBC Asset Management NV, et al. v. Kevin J. McNamara, et al.*, No. 13-cv-01854-UNA (D. Del.); (iii) *North, et al. v. Kevin J. McNamara, et al.*, No. 1:13-cv-00833-MRB (S.D. Ohio); and (iv) any governmental or regulatory agency's claims in, or any right to relief from, any criminal or civil action against any of the Releasees.

[3] As used with respect to Releasees, "affiliates" means entities controlling, controlled by or under common control with Chemed.

state, federal or common law, based upon, arising out of, relating to, or in connection with the Settled Claims of the Settlement Class or any Releasor. Accordingly, to the full extent provided by the PSLRA, upon the Effective Date of the Settlement, the Court bars all claims for contribution: (i) against the Releasees; and (ii) by the Releasees against any person or entity other than any person or entity whose liability to the Settlement Class has been extinguished pursuant to the Stipulation and this Judgment. Any final verdict or judgment obtained by or on behalf of Lead Plaintiffs, the Settlement Class or any Settlement Class Member shall be reduced as provided by the PSLRA.

10. Upon the Effective Date of the Settlement, Defendants and the other Releasees, on behalf of themselves and their respective heirs, executors, administrators, predecessors, successors and assigns of any of them, and all persons acting in concert with any such person, waive, release, forever discharge and dismiss, with prejudice, and agree not to institute, maintain or prosecute any and all claims (including any claim that this Stipulation was fraudulently induced), rights or causes of action or liabilities whatsoever, whether based on federal, state, local, statutory or common law or any other law, rule or regulation (whether foreign or domestic), including both known claims and Unknown Claims, that have been or could have been asserted in the Action or any forum by Releasees or their successors and assigns of any of them against any of the Lead Plaintiffs, Releasors or Plaintiffs' Counsel, which arise out of or relate in any way to the institution, prosecution, or settlement of the Action (except for claims to enforce the Settlement) (the "Settled Defendants' Claims") against the Releasors. Upon the Effective Date of the Settlement, the Settled Defendants' Claims of all the Releasees are hereby compromised, settled, released, discharged and dismissed as against the Releasors on the merits and with prejudice by virtue of the proceedings herein and this Judgment.

11. Each Settlement Class Member, whether or not such Settlement Class Member executes and delivers a Proof of Claim, is bound by this Judgment, including, without limitation, the release of claims as set forth in the Stipulation.

12. This Judgment, the Stipulation, any of its terms and provisions, any of the negotiations or proceedings connected with it, or any of the documents of statements referred to therein:

(a) shall not be offered or received against any Defendant or Releasee as evidence of, or construed as or deemed to be evidence of, any presumption, concession, or admission by any Defendant or Releasee with respect to the truth of any fact alleged by any of the plaintiffs or the validity of any claim that has been or could have been asserted in the Action or in any litigation, or the deficiency of any defense that has been or could have been asserted in the Action or in any litigation, or of any liability, negligence, fault or wrongdoing of any Defendant or Releasee;

(b) shall not be offered or received against any Defendant or Releasee as evidence of a presumption, concession or admission of any fault, misrepresentation or omission with respect to any statement or written document approved or made by any Defendant or Releasee;

(c) shall not be offered or received against any Defendant or Releasee as evidence of a presumption, concession or admission with respect to any liability, negligence, fault or wrongdoing, or in any way referred to for any other reason as against any Defendant or Releasee, in any other civil, criminal or administrative action or proceeding, other than such proceedings as may be necessary to effectuate the provisions of the Stipulation; provided, however, that if the Stipulation is approved by the Court, the

Settling Parties may refer to it to effectuate the liability protection granted them hereunder;

(d) shall not be construed against any Defendant or Releasee as an admission or concession that the consideration to be given hereunder represents the amount which could or would have been recovered after trial; and

(e) shall not be construed as or received in evidence as an admission, concession or presumption against Lead Plaintiffs or any of the Releasors that any of their claims are without merit, or that any defenses asserted by any Defendants have any merit, or that damages recoverable under the Complaint would not have exceeded the Settlement Amount or the Settlement Fund.

13. The Court finds that all parties and their counsel have complied with each requirement of Rule 11 of the Federal Rules of Civil Procedure as to all proceedings herein.

14. In the event that the Settlement does not become effective in accordance with the terms of the Stipulation, then this Judgment shall be rendered null and void to the extent provided by and in accordance with the Stipulation and shall be vacated, and in such event, all orders entered and releases delivered in connection herewith shall be null and void to the extent provided by and in accordance with the Stipulation.

15. A separate order shall be entered regarding Co-Lead Counsel's application for attorneys' fees and expenses as allowed by the Court. A separate order shall be entered regarding the proposed Plan of Allocation for the Net Settlement Fund. Such orders shall in no way disturb or affect this Judgment and shall be considered separate from this Judgment.

16. Exclusive jurisdiction is hereby retained over the Settling Parties and the Settlement Class Members for all matters relating to this Action, including the administration,

interpretation, effectuation or enforcement of the Stipulation and this Judgment, and including any application for fees and expenses incurred in connection with administering and distributing the settlement proceeds to the members of the Settlement Class.

17. The Settling Parties are hereby directed to consummate the Stipulation and to perform its terms.

18. Without further Order of the Court, the Settling Parties may agree to reasonable extensions of time to carry out any of the provisions of the Stipulation.

Dated: _____, 2014.

_____
Honorable Michael R. Barrett
United States District Judge