PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2017-D12

PROVIDER – Hall Render
Individual, Optional and CIRP DSH Dual/SSI Eligible Group Appeals – Medicare Fraction

Provider Nos.: Various

vs.

MEDICARE CONTRACTOR –
Wisconsin Physicians Services,
Palmetto GBA c/o National Government Services,
CGS Administrators

DATE OF HEARING –
March 17, 2015

Cost Reporting Periods Ended:
December 31, 2004 – June 30, 2009

CASE NOs.:
07-0413, 07-2872G, 09-1039GC, 09-1830G, 09-1863GC, 12-0365GC, 12-0373GC, 12-0412, 13-0140GC, 13-0591, 15-0266 and 15-0270

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ISSUE

Whether Medicare Disproportionate Share Hospital ("DSH") reimbursement calculations for the Providers ("Hospitals") were understated due to the failure of the Centers for Medicare & Medicaid Services ("CMS") and the relevant Medicare administrative contractors ("Medicare Contractors")[1] to include all supplementary security income ("SSI") eligible patient days in the numerator of the Medicare fraction of the Medicare DSH percentage, as required by 42 U.S.C. § 1395ww(d)(5)(F)(vi).[2]

DECISION

After considering the Medicare law and regulations, the parties' contentions, and the evidence submitted, the Provider Reimbursement Review Board ("Board") finds that it lacks the authority to review or mandate specific revisions to CMS' data matching process for the Medicare fraction of the Medicare DSH calculation for the fiscal years at issue. Accordingly, the Board holds that it does not have the authority to reverse the Medicare Contractors' adjustments.

INTRODUCTION

This case consolidates multiple appeals involving numerous acute care hospitals for fiscal years 2004 to 2009.[3] The Hospitals challenge CMS's policy of including only some of the SSI eligibility categories in the numerator of the Medicare fraction of the DSH calculation. The Hospitals claim that, as a result of this policy, they receive less DSH reimbursement than they are entitled.

Each of the Hospitals timely appealed this issue and met the jurisdictional requirements for a hearing. Accordingly, the Board held a consolidated hearing on these appeals on March 17, 2015. The Hospitals were represented by Daniel F. Miller, Esq. of Hall, Render, Killian, Heath & Lyman, P.C. The Medicare Contractors were represented by Brendan G. Stuhan, Esq. of the Blue Cross and Blue Shield Association.

STATEMENT OF THE FACTS

The Medicare program pays inpatient hospital services based on predetermined, standardized amounts subject to certain payment adjustments under Medicare's inpatient prospective payment system ("IPPS").[4] One of these adjustments, the Medicare DSH adjustment, provides additional payments to certain qualifying hospitals that treat a disproportionate share of low income patients.[5] The Medicare DSH adjustment is calculated using two fractions known as the Medicare fraction (also referred to as the SSI fraction or SSI ratio) and the Medicaid fraction. The Medicare fraction is calculated by using: (a) in the numerator, the "number of such hospital's patient days…which were made up of patients who (for such days) were entitled to benefits under part A of the subchapter and were entitled to supplementary security income

[1] The lead Medicare contractor in this case is Wisconsin Physicians Services.
[2] Transcript ("Tr.") at 6-7 and Providers' Post-Hearing Brief at 01828.
[3] The Schedule of Providers is attached as Appendix A and it is organized by fiscal year and case number.
[4] 42 C.F.R. Part 412.
[5] 42 U.S.C. § 1395ww(d)(5)(F)(i)(I) (copy included at Provider Exhibit P-68).

benefits…under subchapter XVI of this chapter…"[6]; and (b) in the denominator, the number of days of care that are furnished to patients who were entitled to Medicare Part A. The dispute in these appeals involves CMS' determination of which patients are "entitled to both Medicare Part A and SSI benefits" for purposes of the Medicare fraction of the DSH calculation.

The SSI program is a federal cash assistance program for low-income individuals who are aged, blind, or disabled,[7] administered by the Social Security Administration ("SSA"). The SSI statute, generally, does not use the term "entitled" to SSI benefits. Rather, the SSI statute typically refers to whether an individual is "eligible for benefits."[8] In order to be eligible for SSI benefits, a person must be: (1) 65 years of age or older, blind or disabled; (2) a lawful resident of the United States; (3) have limited income and resources; (4) not be fleeing to avoid prosecution for a crime or violating a condition of parole; and (5) file an application for benefits.[9]

The Medicare program is an insurance program where an individual is automatically "entitled" to Medicare Part A when the person reaches age 65 and is entitled to Social Security benefits, or becomes disabled and had been entitled to disability benefits for 24 calendar months.[10] In addition, the Medicare program provides that certain qualifying individuals with end stage renal disease are entitled to Medicare Part A.[11]

Unlike entitlement for Medicare Part A benefits, an individual who is currently eligible for SSI benefits may later become *in*eligible for SSI benefits. In this regard, SSA conducts periodic redeterminations to ensure continued eligibility[12] and may terminate,[13] suspend[14] or stop payments to individuals who are temporarily or permanently ineligible for payment of SSI benefits.[15] In particular, SSI eligibility may be lost if a person no longer meets the basic requirements. For example, an individual may lose SSI eligibility if the individual is no longer is disabled or the individual meets one of the following reasons set forth in Sections §§ 416.207-416.216:

1. The individual fails to give the SSA permission to contact financial institutions;[16]
2. The individual fails to apply for other benefits to which the individual may be entitled;[17]
3. The individual fails to participate in drug or alcohol addiction treatment;[18]
4. The individual is absent from the United States for more than 30 days;[19] or
5. The individual becomes a resident of a public institutions or prison.[20]

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[6] 42 U.S.C. 1395d(5)(F)(vi)(I). *See also* 42 C.F.R. § 412.106(b)(2)(i)(B) (copy included at Provider Exhibit P-74).
[7] 42 U.S.C. § 1382 (copy included at Provider Exhibit P-73).
[8] 42 U.S.C. §§ 1381a, 1382(a) (emphasis added) (copies included at Provider Exhibits P-72, P-73 respectively).
[9] *See* 20 C.F.R. § 416.202.
[10] *See* 42 U.S.C. § 426.
[11] 42 U.S.C. § 426-1.
[12] 20 C.F.R. § 416.204.
[13] 20 C.F.R. §§ 416.1331-1335.
[14] 20 C.F.R. §§ 416.1320-1330.
[15] 20 C.F.R. § 1320.
[16] 20 C.F.R. § 416.207.
[17] 20 C.F.R. § 416.210.
[18] 20 C.F.R. § 416.214.
[19] 20 C.F.R. § 416.215.
[20] 20 C.F.R. § 416.211.

Under certain circumstances, the Social Security Administration may not pay benefits for administrative reasons, including removal of a representative payee, an unknown address for the beneficiary, or because of income from a previous month.[21]

After the Medicare DSH legislation was enacted in 1984, the Health Care Financing Administration ("HCFA"), the predecessor to CMS, announced that the Secretary of Health and Human Services, rather than the hospitals, would be solely responsible for computation of the Medicare fraction because the data necessary to compute the Medicare fraction is voluminous and much of this data needed to be obtained from another agency, the Social Security Administration ("SSA").[22] HCFA noted that, as of 1986, the data sources for the computation of the Medicare fraction included approximately 11 million billing records from the Medicare inpatient discharge file and over 5 million records from the SSI file compiled by SSA.[23] To compute the Medicare fraction, HCFA had to match individual Medicare billing records to individual SSI records.[24] Considering the administrative burdens and complexity of the data matching process, HCFA concluded that the Secretary would be responsible for the data matching process, which she would conduct retrospectively for every eligible Medicare hospital on a "federal fiscal year" basis—that is, based on discharges occurring in the federal fiscal year.[25] HCFA/CMS notifies Medicare contractors of the SSI ratios after they are calculated. CMS currently makes this notification by posting the resulting ratios on its website. The Medicare contractors then use the posted SSI ratio to calculate the Medicare DSH percentage used to determine the hospital's Medicare DSH payment adjustment.[26]

The Medicare DSH payment adjustment has been the subject of much litigation and the following case is of particular relevance to this appeal: *Baystate v. Leavitt*, 545 F. Supp. 2d 20 *as amended* 587 F. Supp. 2d 37, 44 (D.D.C. 2008) ("*Baystate*"). In *Baystate*, the plaintiff alleged that the Secretary's process to identify and gather the data necessary to calculate each hospital's SSI ratio was deficient. On April 28, 2010, CMS published Ruling 1498-R to respond to a court order in *Baystate*. This Ruling stated that CMS implemented the court order by recalculating the plaintiff's SSI fractions and Medicare DSH payment adjustments, using a revised data matching process that used "updated and refined SSI eligibility data and Medicare records, and by matching individuals' records with reference to Social Security numbers (SSNs) as well as HICANs and Title II numbers."[27] The Ruling also stated that "in the FY 2011 proposed rule, CMS is proposing to adopt the same revised data matching process" for use with all hospitals and that "[i]n the forthcoming FY 2011 final rule, CMS expects to respond to public comments on the proposed new data matching process, make any changes to such matching process that seem appropriate, and adopt finally a new data matching process."[28] Finally, CMS stated that it

[21] *See* Provider Exhibit P-117 at Tab A (copy of SSA Program Operations Manual ("POMS") § SI 02301.201 (describing certain SSI post-eligibility events)).
[22] 51 Fed. Reg. 31454, 31459 (Sept. 3, 1986).
[23] *Id.*
[24] *Id.*
[25] *Id.* at 31459–31460; 42 C.F.R. § 412.106(b).
[26] 42 C.F.R. § 412.106(b)(5); 42 C.F.R. § 405.1803.
[27] CMS-1498-R at 5 (copy included at Provider Exhibit P-83).
[28] *Id.*

would "use that new data matching process in calculating SSI fractions and DSH payments for specific claims that are found to qualify for relief under this Ruling."[29]

Consistent with Ruling 1498-R, CMS published the new data matching process in the FY 2011 proposed rule published on May 4, 2011[30] and finalized that data matching process in the final rule published on August 16, 2010 ("FY 2011 Final Rule").[31] Significantly, in the preamble to the FY 2011 Final Rule, CMS acknowledged a public comment that: (1) requested that "CMS include both paid and unpaid days for both SSI entitlement and Medicare entitlement such that there would be consistency between the numerator and denominator of the SSI fraction;" and (2) provided examples of "several SSI codes that represent individuals who were eligible for SSI but not eligible for SSI payments, that should be included as SSI-entitled for purposes of the data match process."[32] CMS responded in detail to this comment and explained that CMS interprets SSI entitlement to correspond with any month for which an individual *receives* payment of SSI benefits. In this regard, CMS stated that the three SSI codes denoted as C01, M01, or M02 "accurately captures all SSI-entitled individuals, during the month(s) they are entitled to receive SSI benefits."[33] CMS explicitly rejected the inclusion of other SSA codes because "SSI entitlement can change from time to time" and none of these codes "would be used to describe an individual who was entitled to receive SSI benefits during the month that one of these codes was used."[34] Finally, in the preamble, CMS confirms that "[t]he same data matching process [used for FY 2011 and beyond] will be used to calculate SSI fractions for cost reporting periods covered under the Ruling [1498-R]."[35]

While the new data matching process established in the FY 2011 Final Rule was effective October 1, 2010, Ruling 1498-R directed that the Medicare Contractors apply "the same, unitary relief" consisting of SSI fractions that the Secretary had calculated using the new "suitably revised" data matching process to: (1) any Medicare cost report that had not been settled; and (2) all properly pending Medicare DSH appeals of the SSI fraction data matching process issue.[36] The Ruling noted that hospitals dissatisfied with the initial or revised NPR issued using the new SSI ratios in the Medicare DSH adjustment calculation could seek administrative and judicial review provided they met the jurisdictional and procedural requirements of 42 U.S.C. § 1395oo, the Medicare regulations, and other agency rules and guidelines.[37]

Finally, on April 22, 2015, CMS published Ruling 1498-R2 modifying and amending 1498-R by allowing providers to elect whether to use new Medicare SSI fractions calculated on the basis of

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[29] *Id.* at 5-6.
[30] 85 Fed. Reg. 23852, 24002-24007 (May 4, 2010).
[31] 75 Fed. Reg. 50041, 50280-50281 (Aug. 16, 2010) (copy included at Provider Exhibit P-82).
[32] *Id.* at 50280.
[33] *Id.* at 50280-50281.
[34] *Id.* This include all codes with the "S" prefix indicating a suspension of payment; codes beginning with "N" for nonpayment; code "E01" indicating that the individual had countable income which eliminated the SSI payment; and code "E02" indicating that the patient was not entitled to SSI benefits during that month but became entitled during a subsequent month.
[35] *Id.* at 50285.
[36] CMS-1498-R at 6-7.
[37] *Id.* at 28, 31.

"total days" or "covered days" for cost reports involving patient discharges *prior* to October 1, 2004.[38]

As a result of these Rulings and new regulation, CMS recalculated new SSI percentages for the Hospitals for all of the fiscal years at issue in this appeal. It is the Board's understanding that the Hospitals have received written notice of the recalculation through either an RNPR or NPR (or are slated to receive such notice through an RNPR/NPR), and they contend that: (a) they are adversely impacted by the same methodology (*i.e.*, CMS' recognition of only three SSI codes to denote SSI eligibility); and (b) this methodology adversely reduces their Medicare DSH reimbursement.[39]

DISCUSSION, FINDINGS OF FACT, AND CONCLUSIONS OF LAW

At the outset, the Board notes that the Hospitals are challenging the methodology CMS uses to calculate the SSI fraction (*i.e.*, challenging the data matching process) rather than CMS' execution of that process (*i.e.*, whether that process was executed correctly or accurately). Specifically, the Hospitals dispute CMS' recognition of only three SSI codes (*i.e.*, C01, M01, and M02) in that process to define entitlement to SSI benefits for purposes of the Medicare fraction for the Medicare DSH calculation. The Hospitals argue that federal statute, 42 U.S.C. § 1382h(b), continues non-cash benefits (*i.e.*, Medicaid benefits), and that SSA policy allowing the resumption of SSI cash payments without reapplying illustrates a beneficiary's continued entitlement to SSI benefits.[40] In addition, the Hospitals assert that certain additional SSI codes illustrate continued SSI eligibility even when the individual's SSI payments are suspended or placed in a stop payment status and that these individuals continue to be "entitled to" SSI benefits.[41] Accordingly, the Hospitals conclude that these additional SSI codes should be included in the data matching process used to determine the SSI ratio for the Medicare DSH calculation.

The Hospitals argue that, because the regulation governing the numerator of the Medicare fraction, 42 C.F.R. § 412.106(b)(2)(i)(B), refers to entitlement in two places (*i.e.*, individuals "entitled to both Medicare Part A . . . and SSI"), then each use of that term must be interpreted the same way. That is, as CMS interprets entitlement to Part A to include both paid and unpaid Part A benefits as well Part C-enrolled individuals, then CMS should count individuals entitled to SSI regardless of whether these individuals receive an SSI payment.[42] The Hospitals conclude that CMS violates the language of the Medicare DSH statute and the intent of Congress by only using SSI codes C01, M01 and M02 to determine entitlement to SSI benefits.[43]

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[38] CMS-1498-R2 at 2, 6 (copy included at Provider Exhibit P-114).
[39] Post-Hearing Conference Call (Jan. 6, 2017).
[40] Providers' Optional Responsive Brief, Vol. III, at 01400. *See also* Provider's Supplement to Post Hearing Brief at 01979; Provider Exhibits P-129 – P-132 (copies of a CMS web posting, excerpts from the Medicare Prescription Drug Benefit Manual, excerpts from POMs, and an SSA publication).
[41] *See* Provider Exhibit P-91 (excerpt from the State Verification and Exchange System (SVES and State Online Query (SOLQ) Manual (Apr. 2013) published by SSA).
[42] Providers' Post Hearing Brief, Vol. IV, at 01832-01833.
[43] *See* Tr. 27:15-28:25; Providers' Post Hearing Brief, Vol. IV, at 01856.

The Hospitals explain that they did not identify specific inpatients who, as they maintain, are entitled to SSI benefits but had SSI codes other than C01, M01 or M02 because the data use agreement between CMS and SSA prohibits CMS from releasing this information.[44] To address this problem, the Hospitals introduced evidence of additional patients who were Medicaid-eligible in Virginia and Indiana—two states, known as "209(b)" states, whose Medicaid income eligibility level is higher than that to qualify for SSI.[45] They reasoned that if inpatients in these states are eligible for Medicaid, they are likely to be entitled to SSI benefits but were not identified as such because the SSA-CMS data matching process only identifies those individuals who have SSI-eligibility codes of M01, M02 or C01.[46]

The Hospitals argued that some of these patients had to be "entitled to SSI benefits" but not necessarily receiving SSI benefits and should, therefore, be included in the numerator of the Medicare DSH calculation—in the same way as the inpatients who, for whatever reason, are entitled to Medicare Part A but for whom Part A has made no payment to the hospital are included in the definition of those inpatients "entitled to Medicare Part A benefits." The Hospitals request that the Board remand this case to the Medicare Contractor to recalculate the Medicare DSH adjustments to include all SSI patient days in the Hospitals' Medicare fraction.[47]

In reviewing this case, the Board points to the following excerpt from the Federal regulations at 42 C.F.R. §405.1867:

> [T]he Board must comply with all provisions of Title XVIII of the Act and regulations issued thereunder as well as CMS Rulings . . . . The Board must afford great weight to interpretive rules, general statements of policy, and rules of agency organization, procedure, or practice established by CMS.

Based on 42 C.F.R. § 405.1867, the Board must comply with the CMS Rulings 1498-R and 1498-R2. As previously discussed, the Rulings direct that "the same, unitary relief" consisting of the data matching process approved through notice and comment in the FY 2011 Final Rule be applied to: (1) any Medicare cost report that has not been settled; and (2) all properly pending Medicare DSH appeals of the SSI fraction data matching process issue.[48] Indeed, the Ruling states that it "*resolve[s]* each properly pending appeal of the SSI fraction data matching process issue, by applying a suitably revised data matching process" and further that "CMS' action *eliminates any actual case or controversy* regarding the hospital's previously calculated SSI fraction and DSH payment adjustment and thereby *renders moot* each properly pending claim in a DSH appeal."[49] Thus, as a result of the Ruling, the Board must apply the data matching

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[44] 70 Fed. Reg. 47278, 47440 (Aug. 12, 2005) (copy included at Provider Exhibit P-133). *See also* Provider Exhibit P-135 (communications between the Hospitals' counsel and SSA regarding this issue).

[45] Federal statute, 42 U.S.C. § 1396a(f), allowed states that, as of January 1, 1972, had more stringent Medicaid eligibility criteria than that which was established under the SSI program to maintain this criteria. These states are referred to as "209(b) states." *See Gray Panthers v. Administrator, Health Care Financing Admin., Dep't of Health and Human Servs.*, 629 F.2d 180, 182 (D.C. Cir. 1980), rev'd *sub nom, Schweiker v. Gray Panthers*, 453 U.S. 34, (1981).

[46] Providers' Combined Final Position Paper, Vol. II, at 01100-01101.

[47] Providers, Post Hearing Brief, Vol. IV, at 01827.

[48] Ruling 1498-R at 5-6, 31.

[49] *Id.* at 6 (emphasis added).

process described in great detail in the FY 2011 Final Rule, including what SSI codes the agency will and will not use in calculating the SSI fraction to be applied to all hospitals. In this regard, the preamble explicitly states that "including SSI codes of C01, M01 and M02 accurately captures all SSI-entitled individuals during the month(s) that they are entitle to receive SSI benefits."[50]

In summary, CMS explained in Ruling 1498-R that it was going through the notice and comment rulemaking process to propose and finalize the "suitably revised" data matching process that it would use to provide "the same, unitary relief" to calculate the SSI ratio for open cost reports and any pending DSH SSI appeals. Through this notice and comment process, CMS confirmed that it would utilize three specific SSI codes (*i.e.*, C01, M01, and M02) as part of its data matching process in order to establish SSI entitlement for the purposes of the Medicare DSH calculation. As such, the Board finds that it is bound by Ruling 1498-R and must give great weight to the preamble to the FY 2011 Final Rule (as incorporated into that Ruling) and does not have the authority to grant the relief sought by the Hospitals in these appeals. Based on the above, the Board concludes that CMS wrote Ruling 1498-R and the FY 2011 Final Rule with the intent to bind the Agency and all IPPS hospitals to the specific data matching process prescribed for the cost reporting periods covered by those issuances.

DECISION AND ORDER

After considering the Medicare law and regulations, the parties' contentions, and the evidence submitted, the Board finds that it lacks the authority to review or mandate specific revisions to CMS' data matching process for the Medicare fraction of the Medicare DSH calculation for the fiscal years at issue. Accordingly, the Board holds that it does not have the authority to reverse the Medicare Contractors' adjustments.

BOARD MEMBERS PARTICIPATING:

Clayton J. Nix, Esq.
L. Sue Andersen, Esq.
Charlotte F. Benson, CPA
Jack Ahern, MBA, CHFP

FOR THE BOARD:

/s/
L. Sue Andersen, Esq.
Chairperson

DATE: March 28, 2017

[50] 75 Fed. Reg. 50281.

APPENDIX A
SCHEDULE OF PROVIDERS

Case Name: Deaconess Hospital Individual Appeal FYE 12/31/2004

PRRB Case No. 07-0413

Representative: Hall, Render, Killian, Heath & Lyman, P.C.

Schedule of Provider in Individual Appeal (Schedule A)

Case No.	Provider Number	Provider Name (City, County, State)	Cost Reporting Period	Fiscal Intermediary	Date of NPR	Date of Hearing Request	Number of Days Elapsed	Audit Adjustment Number	Medicare Reimbursement in Dispute	Original Case No.	Date of Add/Transfer
1	36-0038	Deaconess Hospital *(Cincinnati, Hamilton, Ohio)*	12/31/04 10/1/04-12/31/04	CGS	6/7/06	12/1/06	177	11, 40, 41	$ 294,002		
Total:									**$ 294,002**		

Group Name: Indiana 10/01/2004-2006 Medicare DSH Crossover Days Group (III)

PRRB Case No: 07-2872G

Group Representative: Hall, Render, Killian, Heath & Lyman, P.C. (MEDCR-11076)

Schedule of Providers in Group (Schedule A)

Ex. No.	Provider Number	Provider Name *(City, County, State)*	Cost Reporting Period	Fiscal Intrmed.	Date of NPR	Date of Hearing Request	Number of Days Elapsed	Audit Adjustment Number	Medicare Reimbursement in Dispute	Original Case No.	Date of Add/ Transfer
1	15-0009	Clark Memorial Hospital *(Jeffersonville, Clark, Indiana)*	12/31/04 10/1/2004-12/31/2004	WPS	2/23/06	3/20/06	25	23	$ 385,575	06-1281G	11/5/12
2	15-0018	Elkhart General Hospital *(Elkhart, Elkhart, Indiana)*	12/31/04 10/1/2004-12/31/2004	WPS	5/31/06	11/16/06	169	9, 21	$ 763,737	06-1281G	11/5/12
3	15-0030	Henry County Memorial County *(New Castle, Henry, Indiana)*	12/31/04 10/1/2004-12/31/2004	WPS	3/2/06	3/20/06	18	13	$ 97,842	06-1281G	11/5/12
4	15-0002	The Methodist Hospital *(Gary, Lake, Indiana)*	12/31/04 10/1/04-12/31/04	WPS	9/25/06	1/29/07	126	33	$ 881,452	06-1281G 12-0380GC	6/1/12 11/5/12
5	15-0048	Reid Hospital & Health Services *(Richmond, Wayne, Indiana)*	12/31/04 10/1/2004-12/31/2004	WPS	5/25/06	10/30/06	158	n/a	$ 1,114,887	06-1281G	11/5/12
6	15-0024	Wishard Health Services *(Indianapolis, Marion, Indiana)*	12/31/04 10/1/2004-12/31/2004	WPS	7/6/06	1/2/07	180	39	$ 408,233	07-0551	8/14/08
7	15-0009	Clark Memorial Hospital *(Jeffersonville, Clark, Indiana)*	12/31/05	WPS	5/16/07	9/21/07	128	22	$ 2,009,677		
8	15-0018	Elkhart General Hospital *(Elkhart, Elkhart, Indiana)*	12/31/05	WPS	7/18/07	1/4/08	170	n/a	$ 2,564,178		
9	15-0030	Henry County Hospital *(New Castle, Henry, Indiana)*	12/31/05	WPS	11/16/06	2/19/07	95	11	$ 584,880	06-1281G	11/5/12
10	15-0011	Marion General Hospital (Marion, Grant, Indiana)	6/30/05 10/1/04-6/30/05	WPS	12/7/06	1/29/07	53	n/a	$ 201,607	06-1281G	11/5/12
11	15-0058	Memorial Hospital of South Bend *(South Bend, St. Joseph, Indiana)*	12/31/05	WPS	7/18/07	9/21/07	65	20	$ 1,472,897		
12	15-0002	The Methodist Hospitals *(Gary, Lake, Indiana)*	12/31/05	WPS	12/13/07	5/1/08	140	n/a	$ 7,840,310		
13	15-0048	Reid Hospital & Health Services *(Richmond, Wayne, Indiana)*	12/31/05	WPS	9/24/07	10/29/07	35	26	$ 2,771,118		
14	15-0100	St. Mary's Medical Center *(Evansville, Vanderburgh, Indiana)*	06/30/05 10/1/04-6/30/05	WPS	9/28/06	1/22/07	116	25	$ 2,366,281	06-1281G	11/5/12
15	15-0023	Union Hospital *(Terre Haute, Vigo, Indiana)*	8/31/05 10/1/04-8/31/05	WPS	2/8/07	3/16/07	36	n/a	$ 4,066,921	06-1281G	11/5/12
16	15-0024	Wishard Health Services *(Indianapolis, Marion, Indiana)*	12/31/05	WPS	6/13/07	12/7/07	177	31	$ 2,214,645	08-0379	8/14/08
17	15-0009	Clark Memorial Hospital *(Jeffersonville, Clark, Indiana)*	12/31/06	WPS	6/18/08	7/3/08	15	22	$ 2,393,203		
18	15-0018	Elkhart General Hospital *(Elkhart, Elkhart, Indiana)*	12/31/06	WPS	6/20/08	8/5/08	46	23	$ 3,352,749		
19	15-0030	Henry County Memorial Hospital *(New Castle, Henry, Indiana)*	12/31/06	WPS	5/7/08	5/16/08	9	12	$ 671,706		

Group Name: Indiana 10/01/2004-2006 Medicare DSH Crossover Days Group (III)

PRRB Case No: 07-2872G

Group Representative: Hall, Render, Killian, Heath & Lyman, P.C. (MEDCR-11076)

Schedule of Providers in Group (Schedule A)

Ex. No.	Provider Number	Provider Name *(City, County, State)*	Cost Reporting Period	Fiscal Intrmed.	Date of NPR	Date of Hearing Request	Number of Days Elapsed	Audit Adjustment Number	Medicare Reimbursement in Dispute	Original Case No.	Date of Add/ Transfer
20	15-0011	Marion General Hospital *(Marion, Grant, Indiana)*	6/30/06	WPS	9/5/07	11/16/07	72	19	$ 265,282		
21	15-0058	Memorial Hospital of South Bend *(South Bend, St. Joseph, Indiana)*	12/31/06	WPS	7/25/08	10/21/08	88	17	$ 1,362,576		
22	15-0048	Reid Hospital & Health Services *(Richmond, Wayne, Indiana)*	12/31/06	WPS	6/20/08	8/5/08	46	23	$ 3,274,963		
23	15-0100	St. Mary's Medical Center *(Evansville, Vanderburgh, Indiana)*	6/30/06	WPS	12/21/07	4/28/08	129	29	$ 2,774,381		
24	15-0023	Union Hospital, Inc. *(Terre Haute, Vigo, Indiana)*	8/31/06	WPS	2/27/08	5/1/08	64	21	$ 4,153,063		
25	15-0024	Wishard Health Services *(Indianapolis, Marion, Indiana)*	12/31/06	WPS	5/14/08	9/12/08	121	33	$ 2,205,565		
Total:									$ 50,197,728		

Group Name: Trinity Health 2007 Dual Eligible DSH CIRP Group

PRRB Case No.: **09-1039GC**

Group Representative: Hall, Render, Killian, Heath & Lyman, P.C. (100390-000201)

Schedule of Providers in Group (Schedule A)

Intermediary: Wisconsin Physician Services

Ex. No.	Provider Number	Provider Name *(City, County, State)*	FYE	Fiscal Intrmed.	Date of Final Determination	Date of Hearing Request	Number of Days Elapsed	Audit Adjustment Number(s)	Medicare Reimbursement in Dispute	Originally Case No.	Date of Add/ Transfer
1	36-0035	Mount Carmel Health *(Columbus, Franklin, Ohio)*	6/30/07	CGS-OH	9/14/09	2/26/10	165	15, 59	$ 7,354,935		
2	15-0076	St. Joseph Regional Medical Center - Plymouth Campus *(Plymouth, Marshall, Indiana)*	6/30/07	WPS	12/10/08	5/28/09	169	5, 14	$ 734,434		
3	15-0012	St. Joseph Regional Medical Center - South Bend Campus *(South Bend, St. Joseph, Indiana)*	6/30/07	WPS	11/26/08	5/28/09	183	6, 20	$ 3,638,607		
								Total	**$ 11,727,976**		

Group Name: Indiana 2005-2007 Medicare DSH Crossover Days Group (IV)
PRRB Case No.: 09-1830G
Group Representative: Hall, Render, Killian, Heath & Lyman, P.C. (MEDCR-11076)
Schedule of Providers in Group (Schedule A)

Ex. No.	Provider Number	Provider Name (City, County, State)	Cost Reporting Period	Fiscal Intermediary	Date of Final Determination	Date of Hearing Request	Number of Days Elapsed	Audit Adjustment Number		Medicare Reimbursement in Dispute	Original Case No.	Date of Transfer
1	15-0074	Community Hospitals of Indiana *(Indianapolis, Marion, Indiana)*	12/31/05	WPS	12/10/07	6/6/08	179	13, 35	$	131,123	08-2107	8/31/09
2	15-0074	Community Hospitals of Indiana *(Indianapolis, Marion, Indiana)*	12/31/06	WPS	8/19/08	2/11/09	176	36	$	112,249	09-0909	8/31/09
3	15-0011	Marion General Hospital *(Marion, Grant, Indiana)*	6/30/07	WPS	12/17/08	6/4/09	169	24	$	699,100		
Total									$	942,472		

Group Name: Community Healthcare System (IN) 2007 Medicare DSH Crossover Days CIRP Group
PRRB Case No.: 09-1863GC
Group Representative: Hall, Render, Killian, Heath & Lyman, P.C. (MEDCR-11076)
Schedule of Providers in Group (Schedule A)

Lead	Provider Number	Provider Name and City, State	Cost Reporting Period	Fiscal Intermediary	Date Appeal Postmarked	Date of Hearing Request	Number of Days Appeal Untimely	Appeal Adjustment Number	Medicare Reimbursement at Issue in Dispute	Original Case Number and Group Number
	15-0125	The Community Hospital *(Munster, Lake, IN)*	6/30/07	WPS	12/10/08	6/8/09	180	n/a	$ 3,626,228	
	15-0008	St. Catherine Hospital *(East Chicago, Lake, IN)*	6/30/07	WPS	12/10/08	6/8/09	180	n/a	$ 1,057,214	
	15-0034	St. Mary's Medical Center *(Hobart, Lake, IN)*	6/30/07	WPS	12/17/08	6/8/09	173	18	$ 1,143,374	
Total									**$ 5,826,816**	

Group Name: IU Health 10/1/2004 - 2007 Medicare DSH [illegible] Group
PRRB Case No.: 12-[illegible]GC
Group Representative: Hall, Render, Killian, Heath & Lyman P.S.C. (MEDPCR [illegible])
Schedule of Providers in Group: Schedule [illegible]

Ex. No.	Provider Number	Provider Name *(City, County, State)*	Cost Reporting Period	Fiscal Intermediary	Date of Final Determination	Date of Hearing Request	Number of Days Elapsed	Audit Adjustment Number	Medicare Reimbursmt. in Dispute	Original Case No.	Date of Add/ Transfer
1	15-0089	Ball Memorial Hospital *(Muncie, Delaware, Indiana)*	6/30/05 10/1/04-6/30/05	WPS	12/20/06	1/29/07	40	27	$ 3,349,703	06-1281G	5/24/12
2	15-0056	Clarian Health Partners, Inc. *(Indianapolis, Marion, IN)*	12/31/05	WPS	11/21/07	5/15/08	176	77	$ 12,778,995	08-1953 07-2872G	8/5/08 5/24/12
3	15-0089	Ball Memorial Hospital *(Muncie, Delaware, Indiana)*	6/30/06	WPS	8/8/08	10/9/08	62	30	$ 4,378,793	07-2872G	5/24/12
4	15-0089	Ball Memorial Hospital *(Muncie, Delaware, Indiana)*	6/30/07	WPS	12/19/08	6/4/09	167	27	$ 3,048,204	09-1830G	5/24/12
Total									**$ 20,205,992**		

Group Name: Franciscan Alliance 10/1/2004 - 12/31/2004 Medicare DSH Crossover Days CIRP Group
PRRB Case No.: **12-0373GC**
Group Representative: Hall, Render, Killian, Heath & Lyman, P.C. (MEDCR-11076)
Schedule of Providers in Group (Schedule A)

Provider No.	Provider Name and Address (City, State)	Fiscal Year End	Intermediary	Date of Final Determination	Date of Hearing Request	Number of Days Claimed	Audit Adjustment Number	Medicare Reimbursement in Dispute	Organization No.	Date of Add to Group
1	15-0033 Franciscan Health - Beech Grove *(Beech Grove, Marion, IN)*	12/31/04 10/1/04-12/31/04	WPS	9/29/06	3/26/07	178	N/A	$ 1,703,138	07-1783	3/22/13
2	15-0004 St. Margaret Mercy Healthcare Centers (North) *(Hammond, Lake, IN)*	12/31/04 10/1/04-12/31/04	WPS	8/10/06	1/31/07	174	19	$ 1,418,633	06-1281G	5/18/12
Total								$ 3,121,771		

Name: Community Hospitals of Indiana, Inc

PRRB Case No. 12-0412

Representative: Hall, Render, Killian, Heath & Lyman, P.C.

Schedule of Provider in Individual Appeal (Schedule A)

Item No.	Provider Number	Provider Name (City, County, State)	Cost Reporting Period	Fiscal Intermediary	Date of NPR	Date of Hearing Request	Number of Days Part C	Audit Adjustment Number	Medicare Amount in Dispute	Control Case No.	Date of PRRB Appeal
1	15-0074	Community Hospitals *(Indianapolis, Marion, Indiana)*	12/31/04 10/1/04-12/31/04	WPS	8/29/06	2/23/07	178	31	$ 74,144	07-0958	6/12/12
Total:									**$ 74,144**		

Group Name: Ascension 10/01/2004 - 2006 209B Dual Eligible CIRP Group

PRRB Case No. **13-0140GC**

Group Representative: Hall, Render, Killian, Heath & Lyman, P.C.

Schedule of Providers in Group (Schedule A)

Ex. No.	Provider Number	Provider Name (City, County, State)	FYE	FI/MAC	Date of Final Determination	Date of Hearing Request	Number of Days Elapsed	Audit Adjustment Number(s)		Medicare Reimbursement in Dispute	Original Case No.	Date of Add/Transfer
1	15-0084	St. Vincent Hospital & Health Center *(Indianapolis, Marion, IN)*	6/30/05 10/1/04-6/30/05	WPS	5/8/07	9/12/07	127	8, 30	$	5,632	07-2833	12/5/12
2	15-0084	St. Vincent Hospital & Health Center *(Indianapolis, Marion, IN)*	6/30/06	WPS	12/20/07	6/18/08	181	10, 27	$	7,020,477	08-2119	12/5/12
3	07-0028	St. Vincent Medical Center *(Bridgeport, Fairfield, CT)*	9/30/06	WPS	1/8/09	6/12/09	155	35, 36, 66	$	22,432	09-0196GC	2/20/14
	TOTAL								$	7,026,109		

Case Name: University of Virginia Medical Center Individual Appeal FYE 6/30/2007
PRRB Case No. 13-0591
Representative: Hall, Render, Killian, Heath & Lyman, P.C.
Schedule of Provider in Individual Appeal

Provider No.	Provider Number	Provider Name (City, County, State)	Cost Reporting Period	MAC	NPR Date	Date of Hearing Request	Number of Days Pursued	Audit Adjustment Number	Amount in Controversy	Case No.	Date of Add'l Issue
1	49-0009	University of Virginia Medical Center *(Charlottesville, Charlottesville, VA)*	6/30/07	Palmetto	8/28/12	2/4/13	160	10, 34, 37, 61	$ 1,605,059	13-0591	
										13-0885G	2/13/13
										13-2352G	6/7/13
										13-0591	11/12/14
Total:									**$ 1,605,059**		

Case Name: University of Virginia Medical Center Individual Appeal FYE 6/30/2008

PRRB Case No. 15-0266

Representative: Hall, Render, Killian, Heath & Lyman, P.C.

Schedule of Provider in Individual Appeal

Ex. No.	Provider Number	Provider Name (Group Name)	Fiscal Year End	Intermediary	Date of Hearing Request	Date of Hearing Request	Number of Days Claimed	Audit Adjustment Number	Reimbursement Impact	Issue No.	Date of Add'l Issue
1	49-0009	University of Virginia Medical Center (Charlottesville, Charlottesville, VA)	6/30/08	Palmetto	11/28/12	4/4/13	127	35, 36, 58, 59	$ 1,716,539	13-1413G; 13-1415G; 13-1416G;	
										13-1764G	6/10/13
										13-1765G	6/10/13
										15-0266	11/12/14
Total:									$ 1,716,539		

Case Name: University of Virginia Medical Center Individual Appeal FYE 6/30/2009

PRRB Case No. 15-0270

Representative: Hall, Render, Killian, Heath & Lyman, P.C.

Schedule of Provider in Individual Appeal

Group No.	Provider Number	Provider Name (City, County, State)	Fiscal Year Ending	MAC	NPR Date	Date of Hearing Request	Number of Days Claimed	Audit Adjustment Number	Amount in Controversy	Case No.	Date Jurisdiction Transferred
1	49-0009	University of Virginia Medical Center *(Charlottesville, Charlottesville, VA)*	6/30/09	Palmetto	5/16/13	6/3/13	18	30, 31, 62, 63	$ 1,631,086	13-2298G 13-2286G 15-0270	11/12/14
Total:									**$ 1,631,086**		