# PROVIDER REIMBURSEMENT REVIEW BOARD
# HEARING DECISION

2000-D57

**PROVIDER** -
Daniel Freeman Memorial Hospital
Inglewood, California

Provider No. 05-0267

**vs.**

**INTERMEDIARY** -
Blue Cross and Blue Shield Association/
Blue Cross of California

**DATE OF HEARING-**
December 10, 1999

Cost Reporting Period Ended -
June 30, 1993

**CASE NO.** 96-0939

**INDEX**

ISSUES:

1. Did the Intermediary properly include the Provider's inpatient Part B charges with outpatient Part B charges, thereby subjecting the inpatient Part B charges to the 5.8% outpatient cost reduction?

2. Was the Intermediary's calculation of the Provider's disproportionate share ("DSH") adjustment proper?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Daniel Freeman Memorial Hospital ("Provider") is a 367-bed short-term nonprofit hospital located in Inglewood, California. On August 31, 1995, Blue Cross of California ("Intermediary"), issued a notice of program reimbursement ("NPR") for the Provider's fiscal year ended ("FYE") June 30, 1993. Pursuant to audit adjustments 17 and 24, the Intermediary adjusted the Provider's Medicare Part B and Medicare Part A charges. The charges, as adjusted, include in Medicare Part B charges, the charges for ancillary services furnished to Medicare inpatients which were covered under Medicare Part B, because Medicare Part A coverage was not available. Because the charges for inpatient Part B services were included with outpatient charges in the Provider's Medicare cost report, such charges were subject to a 5.8% outpatient cost reduction factor. Subjecting the inpatient Part B charges to the 5.8% outpatient cost reduction factor reduced the Provider's Medicare reimbursement by approximately $20,000.

Pursuant to adjustment 25, the Intermediary revised the amount of the Provider's DSH payments. Pursuant to adjustment 26, the Intermediary adjusted the Provider's settlement data, including Medicare patient days. In adjusting the Provider's Medicare patient days, the Intermediary excluded days of care furnished to the Provider's employees for purposes of apportioning the Provider's Medicare costs between Medicare beneficiaries and other patients, but included the Provider's employee days in total patient days for purposes of computing the Provider's DSH payments. The inclusion of the employee days in the computation of Provider's DSH payments decreased the Provider's reimbursement by approximately $65,000.

On February 16, 1996, the Provider filed a timely appeal with the Provider Reimbursement Review Board ("Board") pursuant to 42 C.F.R. '' 405.1835-.1841 and has met the jurisdictional requirements of those regulations. The Provider was represented by Lloyd A. Bookman, Esquire, of Hooper, Lundy & Bookman, Inc. The Intermediary was represented by Bernard M. Talbert, Esquire, of the Blue Cross and Blue Shield Association.

Issue No. 1: Outpatient Cost Reduction Factor:

During the cost reporting period under appeal, the Provider furnished certain ancillary services to hospital inpatients which were not covered under Medicare Part A, but which were covered under Medicare Part B. These ancillary services included services furnished to inpatients who had (1) exhausted their allowed inpatient days under Part A during the current spell of illness; (2) were determined to be receiving a non-covered level of care; or (3) were otherwise not eligible for or entitled to coverage under Part A. These services are referred to as inpatient Part B ancillary services. The Provider included its charges for the inpatient Part B ancillary services with all other outpatient charges on its FYE 1993 as-filed cost report, because there is no location on the cost report to include these charges as inpatient Part B charges separate from the outpatient charges.

Because the Provider's charges for inpatient Part B ancillary services were included with its outpatient charges on its Medicare cost report, the Provider's Medicare reimbursement for inpatient Part B ancillary services was reduced by the 5.8% outpatient cost reduction factor enacted by Congress pursuant to ' 4151(b)(1) of the Omnibus Budget Reconciliation Act of 1990 ("OBRA90"), codified at 42 U.S.C. ' 1395x(v)(1)(S)(ii). Application of the 5.8% cost reduction factor occurs as follows in the Provider's Medicare cost report:

1. The cost to charge ratio for outpatient services for each ancillary cost center is determined on Worksheet C, Part 11. When computing the cost to charge ratio for hospital outpatient services, operating costs are reduced by 5.8%. Capital costs are reduced by a separate factor, which is not at issue here. This occurs on Worksheet C, Part 11.

2. To determine Medicare reimbursement for hospital outpatient services, the outpatient cost-to-charge ratio determined on Worksheet C, Part II is multiplied by the Provider's Medicare charges for hospital outpatient services, separately for each ancillary cost center. See Worksheet D, Part V.

3. The outpatient charges to which the outpatient cost-to-charge ratio is applied are included in Worksheet D, Part V, Column 5, which is entitled "All Other Part B." Included in Column 5 are charges for inpatient Part B ancillary services. Because these charges were included with outpatient charges in the "All other Part B" charge column, they were subjected to the 5.8% outpatient cost reduction factor in determining the Provider's reimbursement for the inpatient Part B ancillary services.

PROVIDER'S CONTENTIONS:

The Provider contends that the application of the outpatient cost reduction factor to inpatient Part B ancillary services is inconsistent with the plain language of ' 4151(b)(1) of OBRA90, codified at 42

U.S.C. ' 1395x(v)(1)(S)(ii), the statute which included the outpatient cost reduction factor. That statute provides:

> The Secretary shall reduce the reasonable cost of outpatient hospital services (other than the capital related costs of such services) otherwise determined pursuant to Section 1833(a)(2)(B)(i)(1) by 5.8% for payments attributable to portions of cost reporting periods occurring during fiscal years 1991, 1992, 1993, 1994, or 1995.

The Provider contends that the statute directs that the 5.8% reduction should be applied to the reasonable cost of "outpatient hospital services." The Provider contends that services covered under Medicare Part B which are furnished to hospital inpatients are not outpatient hospital services.

The Provider points to the definitions of inpatient and outpatient hospital services in the Medicare Intermediary Manual ("HCFA Pub. 13") to support its position. A hospital inpatient is defined in the MIM as a person who has been admitted to a hospital for bed occupancy for purposes of receiving inpatient hospital services. See HCFA Pub. 13-3 ' 3101. A hospital outpatient is defined as a person who has not been admitted by the hospital as an inpatient but who is registered on the hospital records as an outpatient and received services from the hospital. HCFA Pub. 13-3 ' 3112.1. The Provider contends that it is uncontroverted that the patients who receive the inpatient Part B ancillary services were hospital inpatients. These patients had been admitted to the hospital for bed occupancy in order to receive inpatient hospital services. These patients were not registered on the hospital's records as outpatients.

According to the Provider, because the patients were hospital inpatients and not hospital outpatients, such services are not hospital outpatient services. This outpatient cost reduction factor is to be applied under ' 4151(b)(1) of OBRA, codified at 42 U.S.C. ' 1395x(v)(1)(S)(ii), only to hospital outpatient services, and the outpatient cost reduction factor may not be applied to inpatient Part B ancillary services.

The Provider further notes that the courts have repeatedly held that the most important consideration in determining the meaning of the statute is the plain language of the statute. See Ardestani v. INS, 502 U.S. 129, 112 S.Ct. 515 (1991) and Estate of Cowart v. Niklos Drilling Co., 112 S.Ct. 2589, 2592 (1992). The Provider asserts that the Intermediary has demonstrated no basis for the Board to ignore the plain language of the statute.

The Provider points out that treating inpatient Part B ancillary services differently from hospital outpatient services would be consistent with the approach taken throughout the Medicare program. Inpatient services under Part A, inpatient Part B ancillary services, and hospital outpatient services are treated differently under the Medicare program for various reasons. During the fiscal period at issue,

inpatient Part A services were reimbursed under the Medicare prospective payment system pursuant to the "DRG" methodology and inpatient Part B ancillary services were reimbursed on a reasonable cost basis. Many outpatient services were not reimbursed on a reasonable cost basis. For example, outpatient hospital clinical laboratory services were reimbursed on the basis of a fee schedule. Outpatient radiology and other outpatient diagnostic services were reimbursed on a blend of costs and a fee schedule. Similarly, inpatient Part A services, inpatient Part B ancillary services, and outpatient services are all treated differently in the Medicare claims processing system. Inpatient Part A services are identified as Type 1 services in Medicare claims, inpatient Part B ancillary services are identified as Type 2 services, and outpatient services are identified as Type 3 services.

The Provider also contends that the statutory provisions pertaining to reimbursement for outpatient clinical laboratory services and outpatient radiology services support its position that inpatient Part B ancillary services are not hospital outpatient services for purposes of Medicare reimbursement. The Secretary of Health and Human Services ("Secretary") was directed to establish fee schedules for clinical diagnostic laboratory tests pursuant to 42 U.S.C. ' 13951(h). It states that the "fee schedules are to be provided for clinical laboratory tests . . . for which payment is made under this part, other than such tests performed by a provider of services for an inpatient of such provider." Id. The Secretary has implemented this provision by applying the clinical laboratory fee schedules to only laboratory tests furnished to hospital outpatients, and not to laboratory tests furnished to hospital inpatients, even where such tests are covered under Medicare Part B.

Further, pursuant to 42 U.S.C. ' 13951(a)(2)(E), "outpatient hospital radiology services" are excluded from reimbursement on a reasonable cost basis and are reimbursed pursuant to a blend of costs and a fee schedule amount. The Medicare program has continued to reimburse hospital radiology services furnished to inpatients who have "Part B only" coverage on a reasonable cost basis. It is clear that the program has recognized that outpatient hospital radiology services and inpatient Part B radiology services are different and are not treated in the same fashion for Medicare reimbursement purposes. Thus, the Medicare program has recognized that the term "outpatient hospital services" does not include within it inpatient Part B services.

Finally, the Provider argues that the statutory provisions implementing an outpatient prospective payment system demonstrate that Congress understands hospital outpatient services and inpatient Part B ancillary services to mean different things. Pursuant to 42 U.S.C. ' 13951(t)(1)(A) the new outpatient prospective payment system is to apply to "covered OPD services." The term "covered OPD services" is defined to include (1) hospital outpatient services designated by the Secretary, and (2) inpatient hospital services designated by the Secretary which are covered under Part B and furnished to a hospital inpatient who (i) is entitled to benefits under Part A but has exhausted benefits for inpatient hospital services during a spell of illness, or (ii) is not so entitled. Id. The explicit language used by Congress to subject inpatient Part B ancillary services to the new outpatient prospective payment methodology indicates that the term "hospital outpatient services" does not include inpatient Part B ancillary services. There would have been no need for Congress to separately identify inpatient Part B

ancillary services in the statute if they were included within the meaning of the term "outpatient hospital services." The statute reflects that Congress knew how to clearly and expressly identify outpatient Part B ancillary services when it so intended.

Finally, the Provider contends that the Intermediary's reliance on the cost report instructions is erroneous. If the cost report instructions are interpreted, as the Intermediary contends, to require that inpatient Part B ancillary services be subjected to the outpatient cost reduction factor, then the cost report instructions are invalid as being inconsistent with the Medicare statute. It is clear that a cost report instruction which is inconsistent with a provision of the Medicare Act is invalid. See Pacific Coast Medical Enterprises v. Harris, 633 F.2d 123 (9th Cir. 1980.)

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that the Medicare cost report instructions, specifically HCFA Pub. 15-2 ' 2814.5 require that inpatient Part B ancillary charges be included with outpatient charges in the Medicare cost report for purposes of cost apportionment. It states that:

> [t]his worksheet provides for the apportionment of costs applicable to hospital outpatient services reimbursable under titles V, XVIII, and XIX, as well as inpatient services reimbursable under title XVIII, Part B.

HCFA Pub. 15-2 ' 2814.5.

The outpatient cost reduction factor, or sequestration adjustment, is made after determining the amount of total Medicare payment due to the provider for covered services furnished to eligible beneficiaries during the cost reporting year. In preparing the cost report, a provider would apply the appropriate reduction percentage to reduce the total net costs reimbursable to the provider as part of the process of arriving at the balance due the provider/program on Worksheet E, Part B. Since the reduction rate in question affects Part B only, the Intermediary is required to apply the effective rate to Worksheet E, Part B of the Provider's cost report. The Intermediary contends that it was required to follow the cost report instructions.

The Intermediary also contends that the Provider's position would require the Medicare program to adopt a three tier reimbursement methodology. The Intermediary contends that the Medicare program only contemplates a two tier reimbursement methodology, one tier for hospital outpatient services and a second tier for all services furnished under Medicare Part B.

Issue No. 2: Disproportionate Share Reimbursement:

The Provider is self-insured for the health insurance of its employees in a manner that meets the definition of self-insurance in HCFA Pub. 15-1 ' 2162.7. Therefore, many of the Provider's employees choose to be hospitalized at the Provider's hospital facility when inpatient care is needed. The Provider has made arrangements for a third party administrator to administer the costs/benefits of its employees' health insurance and this third party administrator pays the Provider out of the Provider's self-insured health insurance fund for the inpatient care required by the Provider's employees while hospitalized at the Provider.

The Intermediary, pursuant to audit adjustment 48, reduced the Provider's total days on Worksheet S-3 by the number of days of care furnished to the Provider's employees.[1] The Intermediary's adjustment was made in accordance with HCFA Pub. 15-2 ' 332 which authorizes the exclusion of employee days from total patient days for Medicare cost reporting purposes. The Intermediary, however, added the employee days to total patient days for purposes of determining the Provider's DSH payments. The inclusion of the employee days in total patient days for purposes of computing the Provider's DSH payments reduced the Provider's reimbursement by approximately $65,000.

PROVIDER'S CONTENTIONS:

When Congress enacted the Medicare prospective payment system ("PPS"), it adopted a methodology for providing additional payments to hospitals which treated a disproportionate share for low income patients. See 42 U.S.C. ' 1395ww(d)(5)(F)(i) and 42 C.F.R. ' 412.106. One of the components used in computing the DSH payment adjustment is the number of the Provider's Medicaid patient days divided by total patient days. 42 U.S.C. ' 1395ww(d)(5)(F)(i) and 42 C.F.R. ' 412.106(b).

The Provider contends that employee days should be excluded from total patient days for purposes of computing the Provider's DSH payments. The Provider notes that the statute does not describe the manner in which total patient days should be computed for purposes of the DSH calculation, and neither the statute nor the regulation address the question of whether employee days should be included in total patient days for purposes of the DSH calculation.

Because neither the statute nor the regulations address whether total patient days should include employee days for purposes of the DSH computation, the Provider contends that the approach used by the Medicare program in determining total patient days for cost reporting purposes generally should be

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[1] Tr. at 35.

applied when determining total patient days for purposes of the DSH payment adjustment.

In this case, the Intermediary excluded employee days from total patient days on Worksheet S-3, in apportioning the Provider's Medicare costs on its Medicare cost report. This adjustment was made pursuant to HCFA Pub. 15-1 ' 332.1, which states that "where an average cost per diem is used to apportion costs, the days applicable to the employees who receive the allowances should be removed from the total days used to apportion costs." Because the Intermediary removed the employee days from total patient days, it is clear that HCFA Pub. 15-1 ' 332.1 was applicable and that the employee days must be excluded from total patient days.

The Provider contends that patient days should be treated consistently throughout the Provider's Medicare cost report. If patient days are excluded for cost apportionment purposes, they should be excluded for DSH payment purposes as well. The Provider asserts that its position is consistent with a memorandum issued by HCFA in 1990, which states that labor room days and the days applicable to employees who are admitted to the hospital should also be excluded from the number of total days for purposes of the DSH calculation.[2]

The Provider contends that Congress must be presumed to have understood the manner in which HCFA accounted for patient days for Medicare cost reporting purposes when it enacted the DSH adjustment. Thus, it should be presumed that the term "patient days" as used in the DSH payment adjustment was intended to have the same meaning by Congress as patient days used for other purposes throughout the Medicare program. Accordingly, under the circumstances here, where employee days are excluded from total patient days for cost reporting purposes, employee days should also be excluded from the DSH computation.

The Provider contends that the Board's decision in Rogue Valley Medical Center v. Medicare Northwest, PRRB Dec. No. 98-D22, January 21, 1998, Medicare and Medicaid Guide (CCH) 46,019, HCFA Administrator, declined rev., March 6, 1998 ("Rogue Valley") was wrongfully decided. Specifically, the Provider believes that the Board appears not to have considered the argument being made by the Provider in this case that Congress is presumed to have been aware of the treatment of employee days for cost apportionment purposes when it adopted the DSH statute, and must be presumed to have intended a consistent approach for purposes of DSH reimbursement and cost apportionment.

INTERMEDIARY'S CONTENTION:

The Intermediary contends that the Medicare regulation addressing disproportionate share payments, 42 C.F.R. ' 412.106, does not provide that employee days should be excluded from total patient days.

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[2] See Provider Exhibit 1.

The Intermediary notes that the regulation indicates that patient days include all those inpatient areas of the hospital subject to PPS, and that this would be applicable to hospital employees. The Intermediary contends that there is no basis for excluding employee days from total patient days for purposes of the DSH computation.

The Intermediary contends that the Board correctly decided this issue in Rogue Valley, supra.

CITATION OF LAW, REGULATIONS AND PROGRAM INSTRUCTIONS:

1. Law - 42 U.S.C.:

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| ' 1395l(a)(2)(E) | - | Amount of Payment |
| ' 1395l(h) | - | Clinical Diagnostic Laboratory Services |
| ' 1395l(t)(1)(A) et seq. | - | PPS for Hospital Outpatient Services |
| ' 1395x(v)(1) et seq. | - | Reasonable Cost |
| ' 1395ww(d) et seq. | - | PPS Transition Period |

2. Regulations - 42 C.F.R.:

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| '' 405.1835-.1841 | - | Board Jurisdiction |
| ' 412.106 et seq. | - | Special Treatments: Hospitals That Serve a Disproportionate Share of Low-income patients |
| ' 413.124 | - | Reduction to Hospital Outpatient Operating Costs |

3. Program Instructions- Provider Reimbursement Manual (HCFA Pub. 15-1 ):

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| ' 2162.7 | - | Conditions Applicable to Self-Insurance |

4. Program Instructions- Provider Reimbursement Manual (HCFA Pub. 15-2 ):

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| ' 332 et seq. | - | Allowance to Employees |
| ' 2814.5 | - | Part V - Apportionment of Medical and Other Health Services Costs: |

5. Medicare Intermediary Manual (HCFA Pub 13-3):

' 3101 - Covered Inpatient Hospital Services

' 3112.1 - Outpatient Defined

6. Cases:

Ardestani v. INS, 502 U.S. 129 (1991)

Estate of Cowart v. Niklos Drilling Co., 112 S.Ct. 2589 (1992)

Pacific Coast Enterprises v. Harris, 633 F.2d 123 (9th Cir. 1980).

Rogue Valley Medical Center v. Medicare Northwest, PRRB Dec. No. 98-D22, January 21, 1998, Medicare and Medicaid Guide (CCH) & 46,019, HCFA Administrator, declined rev., March 6, 1998.

FINDINGS OF FACT, CONCLUSIONS OF LAW, AND DISCUSSION:

The Board, after consideration of the facts, parties' contentions, and evidence submitted, finds and concludes that:

Issue No. 1: Outpatient Part B Cost Reduction Factor

The Board finds that based on the plain language of the applicable statute and the Secretary's own regulation, the outpatient reduction factor at issue in this case may not be applied to inpatient Part B services. The Board notes that the applicable statute, 42 U.S.C. ' 1395(x)(v)(1)(S)(ii)(II) provides as follows:

> The Secretary shall reduce the reasonable cost of outpatient hospital services (other than the capital-related costs of such services) otherwise determined pursuant to section 1833(a)(2)(B)(II) [42 U.S.C. ' 1395l(a)(2)(B)(II)] of this title to be 5.8 percent for payments attributable to portions of cost reporting periods occurring during fiscal years 1991 through 1999 and, during fiscal years 2000 before January l, 2000.

Similarly, the Secretary's regulation at 42 C.F.R. ' 413.124 indicates that the 5.8 percent reduction only applies to outpatient services:

> [T]he reasonable costs of outpatient hospital services (other than capital related costs of such services) are reduced by 5.8 percent for services rendered during portions of cost reporting periods occurring on or after October 1, 1990 and before October 1, 1998.

The Board finds that the above statute and regulation specifically refer to the reduction of outpatient services. The Board notes that there was nothing in evidence of notice given by the Secretary of her intent to reduce inpatient Part B costs. The Board further notes that the Intermediary did not challenge the Provider's claim that the inpatient Part B services at issue were in fact furnished to hospital inpatients, not hospital outpatients; therefore, they constitute hospital inpatient services, not hospital outpatient services. Accordingly, as noted above, the Board concludes that based on the plain language of the statute and regulation, the outpatient cost reduction factor may not be applied to inpatient Part B services.

The Board also finds that its conclusion is supported by the language in the statute instructing the Secretary to adopt a prospective payment system for hospital outpatient services. The Board believes that Congress was aware that hospital outpatient services and inpatient Part B services were different by the definition of covered outpatient department services. Covered outpatient department services include: (1) hospital outpatient services designated by the Secretary; and (2) inpatient hospital services designated by the Secretary that are covered under Part B and furnished to a hospital inpatient . . . See 42 U.S.C ' 1395l(t)(1)(D). By separately designating hospital outpatient services and inpatient hospital services covered under Part B, Congress indicated clearly that hospital outpatient services and inpatient hospital services covered under Part B are different.

The Board notes that the Intermediary points out that it used the existing cost report forms and instructions and that these forms and instructions apply the 5.8 percent reduction factor to inpatient Part B services in addition to outpatient services. The Board believes that to the extent that cost report forms and instructions require the resultant reduction to inpatient Part B services, the forms and instructions are contrary to statute and regulation at 42 U.S.C. ' 1395(x)(v)(1)(S)(ii)(II) and 42 C.F.R. ' 413.124 respectively, and are therefore invalid. The Board believes that if the forms and instructions are wrong and contrary to the statute and regulation, HCFA should correct them.

The Board also rejects the Intermediary's contention that the Provider is impermissibly creating a three tier approach to Medicare reimbursement. The Board agrees with the Provider that the Medicare program has encompassed a three tier approach, establishing separate reimbursement methodologies for inpatient Part A services (DRG-based reimbursement), inpatient Part B ancillary services (reasonable cost reimbursement), and hospital outpatient services (a mix of reasonable cost

reimbursement, fee schedule reimbursement, and a blend of fee schedule and reasonable cost reimbursement). Thus, the Board finds that the Provider's approach of treating inpatient Part B ancillary services differently from hospital outpatient services is consistent with the general approach used by the Medicare program.

Issue No. 2: Disproportionate Share Payment Adjustment

The Board finds that its decision in Rogue Valley, supra, is applicable to the instant case.

The Board finds the controlling authority for determining DSH adjustments at 42 C.F.R. ' 412.106. In part, the regulation describes the factors used in the DSH determination as well as the methodology to be employed. With respect to the "total number of patient days" factor, which is at issue in this appeal, (42 C.F.R. ' 412.106(b)(4)) the Board finds the regulation silent regarding the inclusion or exclusion of self-insured patient days. The regulation provides only that:

> [t]he number of patient days includes only those days attributable to areas of the hospital that are subject to the prospective payment system and excludes all others.

42 C.F.R. ' 412.106 (a)(ii).

Since there is no dispute that the subject self-insured patient days are attributable to patient stays in areas of the Provider=s operation subject to PPS, and since the Board finds no other program instruction which elaborates upon the definition of total patient days used in the DSH determination, the Board concludes that patient days attributable to the self-insured employees must be used in the DSH calculation.

The Board rejects the Provider's argument that HCFA Pub. 15-2 ' 332.1 supports its position because the manual requires charges and patient days related to self-insured plans to be excluded from reimbursement statistics used in the Medicare cost-finding process. First, the Board finds no connection between the provisions of HCFA Pub. 15-2 ' 332.1 and the calculation of the DSH adjustment. The manual explains how the costs of services furnished to employees as a fringe benefit are recovered through the Medicare cost-finding process. While the manual instruction does require an adjustment to "total days used to apportion costs," it is not necessarily applicable to the DSH calculation. The Board notes that the DSH calculation is performed "outside" the Medicare cost report, meaning it is not a function of the Medicare cost finding process. The Board also finds that the memorandum cited by the Provider[3] is not pertinent to the specific issue in this case.

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[3] See Provider Exhibit 1.

Absent any authority to exclude employee days from the DSH calculation, the Board finds that the Intermediary's inclusion of these days in the DSH calculation was proper.

DECISION AND ORDER:

Issue No. 1: Outpatient Part B Cost Reduction Factor

The Intermediary improperly applied the outpatient cost reduction factor to the Provider's inpatient Part B services. The Intermediary is ordered to compute an adjustment to the Provider's Medicare reimbursement to remove the application of the outpatient Part B reduction factor from the Provider's inpatient Part B costs.

Issue No. 2: Disproportionate Share Payment Adjustment

The Intermediary's calculation of the DSH adjustment including employee self-insured days in the calculation was proper. The Intermediary-s calculation of the Provider's DSH adjustment is affirmed.

Board Members Participating:

Irvin W. Kues
Henry C. Wessman, Esquire
Martin W. Hoover, Jr. , Esquire
Charles R. Barker
Stanley J. Sokolove

FOR THE RECORD

Irvin W. Kues
Chairman