PROVIDER REIMBURSEMENT REVIEW BOARD
DECISION

ON THE RECORD
2014-D14

PROVIDER –
Swedish American Hospital

Provider No.: 14-0228

vs.

INTERMEDIARY –
BlueCross BlueShield Association/
Wisconsin Physicians Service

DATE OF HEARING -
June 20, 2013

Cost Reporting Periods Ended -
May 31, 1999; May 31, 2000;
May 31, 2001; May 31, 2002 and
May 31, 2003

CASE NOs.: 05-1891; 05-1887;
04-1831; 05-0731 and 06-1938

INDEX

ISSUE:

Whether the Temporary Cap Increase Exception applies to the Provider's 1996 base year IME/GME FTE[1] count for osteopathic and allopathic medicine interns and residents and the caps application to the May 31, 1999 through May 31, 2003 FTE counts?

MEDICARE STATUTORY AND REGULATORY BACKGROUND:

This is a dispute over the amount of Medicare reimbursement due a provider of medical services.

The Medicare program was established under Title XVIII of the Social Security Act, as amended ("the Act"), to provide health insurance to eligible individuals. Title XVIII of the Act was codified at 42 U.S.C. Chapter 7, Subchapter XVIII. The Centers for Medicare and Medicaid Services ("CMS," formerly the Health Care Financing Administration ("HCFA")) is the operating component of the Department of Health and Human Services ("DHHS") charged with administering the Medicare Program. CMS' payment and audit functions under the Medicare program are contracted out to organizations known as fiscal intermediaries ("FIs") and Medicare administrative contractors ("MACs"). FIs and MACs determine payment amounts due the providers under Medicare law, regulations and under interpretive guidelines published by CMS.[2]

Providers submit cost reports on an annual basis to the fiscal intermediary with reporting periods based on the provider's accounting period. A cost report shows the provider's costs incurred during the relevant fiscal year and the portion of those costs to be allocated to the Medicare program.[3] The intermediary reviews the cost report, determines the total amount of Medicare reimbursement due the provider, and issues the provider a Notice of Program Reimbursement ("NPR").[4] A provider dissatisfied with the intermediary's final determination of total reimbursement may file an appeal with the Provider Reimbursement Review Board ("Board") within 180 days of the receipt of the NPR.[5]

THE BALANCED BUDGET ACT OF 1997 ("BBA")

In 1997, Congress enacted the Balanced Budget Act of 1997 ("BBA").[6] Among other things, the BBA changed the way in which FTE residents were counted for purposes of calculating the IME adjustment and GME payments for teaching hospitals.

The BBA capped the number of allopathic and osteopathic residents that a hospital could count for purposes of calculating the IME adjustment and GME payments. Specifically, the BBA provided that a hospital's total number of FTE residents in the fields of allopathic and

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[1] IME = Indirect Medical Education
GME = Graduate Medical Education
FTE = Full Time Equivalent

[2] *See* 42 U.S.C. §§ 1395h, 1395kk-1; 42 C.F.R. §§ 413.20, 413.24.

[3] *See* 42 C.F.R. §413.20.

[4] *See* 42 C.F.R. §405.1803.

[5] *See* 42 U.S.C. §1395oo(a); 42 C.F.R. §§405.1835-1837.

[6] Pub. L. No. 105-33, 111 Stat. 251 (1997).

osteopathic medicine in a hospital or nonhospital setting could not exceed the number of FTE residents with respect to the hospital's most recent cost reporting period ending on or before December 31, 1996 ("FTE Resident Cap").[7] For the IME adjustment, the FTE resident cap applies to discharges occurring on or after October 1, 1997.[8] For GME payments, the FTE resident cap applies to cost reporting periods beginning on or after October 1, 1997.[9] Furthermore, the BBA provided the Secretary with rulemaking authority to implement the FTE resident caps.

AUGUST 1997 FINAL RULE

The Secretary exercised this authority by promulgating a series of regulations in the final rules for the hospital inpatient prospective payment system ("IPPS") for FY 1998. The first regulatory provisions addressing FTE resident caps appeared in the August 29, 1997 IPPS final rule, as corrected by final rules dated September 8, 1997 and September 18, 1997 ("August 1997 Final Rule").[10]

For purposes of GME payment and IME adjustment, the August 1997 Final Rule limited the FTE resident cap to the hospital's unweighted FTE count for these residents for the most recent cost reporting period ending on or before December 31, 1996.[11] This cap became effective for cost reporting periods beginning on or after October 1, 1997.

MAY 1998 FINAL RULE

Pertinent to this case, in the IPPS Final Rule for FY 1999 ("May 1998 Final Rule"), the Secretary responded to comments on the direct GME and IME provisions of the August 1997 Final Rule.[12] The Secretary addressed a scenario where a hospital began training additional residents after its cost reporting period ended during 1996 because another hospital closed or discontinued its teaching programs during the July 1996 through June 1997 residency year. With respect to that scenario, the Secretary stated the following:

> [W]e agree that, when a hospital takes on residents because another hospital closes or discontinues its program, a temporary adjustment to the [FTE resident] cap is appropriate and consistent with the base year system. In these situations, residents may have partially completed a medical residency program and would be unable to complete their training without a residency position at

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[7] BBA §§ 4621(b)(1), 4623 (codified at 42 U.S.C. §§ 1395ww(d)(5)(B) and 1395ww(h)(4)(F) respectively).
[8] *Id.*
[9] *Id.*
[10] *See* 62 Fed. Reg. 45966 (Aug. 29, 1997); 62 Fed. Reg. 47237 (Sept. 8, 1997); 62 Fed. Reg. 49049 (Sept. 18, 1997).
[11] *See* 62 Fed. Reg. at 46004. For GME payment, the applicable regulation was promulgated at 42 C.F.R. § 413.86(g)(4), and, for the IME adjustment, the applicable regulation was promulgated at 42 C.F.R. §412.105(f)(1)(C)(iv). *See id.* at 46029, 46034-46035.
[12] 63 Fed. Reg. 26318 (May 12, 1998).

> another hospital. We believe that it is appropriate to *allow temporary adjustments* to the FTE [resident] caps for a hospital that provides residency positions to medical residents who have partially completed a residency training program *at a hospital which has closed.*
>
> For purposes of this final rule, we will *allow for temporary adjustments* to a hospital's FTE [resident] cap to reflect residents affected by *a hospital closure*. That is, *we will allow an adjustment to a hospital's FTE [resident] cap if the hospital meets the following criteria*: (1) During the July 1996-June 1997 residency year the hospital assumed additional medical residents from a hospital that was closing; (2) The hospital added the residents with the intent of allowing them to complete their education program; and (3) The hospital that closed does not seek reimbursement for the residents. As stated above, *this adjustment will be temporary* to allow Medicare payment for those residents from the closed hospital. *After this period, the hospital's [FTE resident] cap will be based solely on the statutory base year.* Hospitals seeking an adjustment for this situation must document to their intermediary that an adjustment is warranted for this purpose and the length of time that the adjustment is needed.[13]

Thus, CMS stated in the preamble that if, in connection with the July 1996-June 1997 residency year, the hospital assumed additional medical residents from another hospital that was closing, it "will allow" that hospital to adjust its FTE resident caps on a temporary basis if it meets certain specified criteria. However, CMS did not incorporate this allowance policy into the regulations governing GME and IME at then 42 C.F.R. §§ 413.86 or 412.105.

JULY 1999 FINAL RULE

Effective October 1, 1999, in the IPPS Final Rule for FY 2000 ("July 1999 Final Rule") CMS did revise the regulation at 42 C.F.R. § 413.86(g)(8) (1999) to allow the temporary adjustment to FTE resident caps because of another hospital's closure.[14] The revised regulation allowed a temporary FTE resident cap adjustment because of another hospital's "closure" if the hospital meets the following criteria:

> (i) The hospital is training additional residents from a hospital that closed on or after July 1, 1996.
> (ii) No later than 60 days after the hospital begins to train the residents, the hospital submits a request to its fiscal intermediary for a temporary adjustment to its FTE cap, documents that the hospital is eligible for this temporary adjustment by identifying the

[13] *Id.* at 26330 (emphasis added).
[14] 64 Fed. Reg. 41490, 41522-41523, 41543 (July 30, 1999).

> residents who have come from the closed hospital and have caused the hospital to exceed its cap, and specifies the length of time the adjustment is needed.
> (iii) For purposes of paragraph (g)(8) of this section, "closure" means the hospital terminates its Medicare agreement under the provisions of § 489.52 of this chapter.[15]

The regulation was silent regarding the adjustment of an FTE resident cap when a hospital closed/discontinued a residency program.

AUGUST 2001 FINAL RULE

In the IPPS Final Rule for FY 2002 published on August 1, 2001 ("August 2001 Final Rule"),[16] CMS revised 42 C.F.R. §413.86(g)(8) to expand the situations that qualify for a temporary adjustment to the FTE resident cap. Specifically, CMS revised that regulation to also allow a hospital to temporarily adjust its FTE resident cap when a hospital assumes the training of additional residents because another hospital closes its residency teaching program. The regulation as revised required the hospital that is closing its residency training program to temporarily reduce its FTE resident cap according to the criteria specified in § 413.86(g)(8)(i)(B) and (g)(8)(iii)(B) and allow the hospital training the displaced residents to receive a temporary increase to its FTE resident cap for direct GME to reflect residents added because of the closure of the residency training program if the criteria at then 42 C.F.R. §413.86(g)(8)(iii) are met.[17] CMS incorporated similar provisions, in the August 2001 Final Rule, for IME at then 42 C.F.R. § 412.105(f)(1)(ix).[18] CMS stated that the foregoing adjustment provisions would only be applicable to cost reporting periods (for direct GME) and discharges (for IME) beginning on or after October 1, 2001.[19]

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Swedish American Hospital ("Provider") was a 293-bed acute care hospital that included a 20-bed hospital-based psychiatric unit located in Rockford, Illinois. The Provider's fiscal year end is May 31st and the fiscal years ("FYs") at issues are 1999 through 2003. During this time, the Provider's fiscal intermediary was Mutual of Omaha ("Intermediary").

The Provider participated with the University of Illinois, College of Medicine at Rockford ("University") in a Family Practice Residency Program (Program). An agreement between the Provider and University was in effect for the audit of the Provider's base year of FY 1996.[20] The Intermediary made final determinations (both in the initial NPRs and Revised NPRs ("RNPRs")) on the Provider's Medicare cost reports, adjusting the IME/GME FTE resident cap to reflect the interns and residents FTEs at the hospital during the Provider's 1996 base year cost reporting

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[15] *Id.* at 41543.
[16] 66 Fed. Reg. 39828 (Aug. 1, 2001).
[17] *Id.* at 39937-39938.
[18] *Id.* at 39933-39934.
[19] *Id.* at 39828, 39899-39901.
[20] *See* Intermediary Exhibit I-1.

period. The Intermediary established an FTE resident cap of 12.38 FTE residents for the IME program and 15.05 FTE residents for the GME program.[21] This resident count is reflected in the Provider's resident rotation schedules for FY 1996 included at Provider Exhibit P-49, pages 17 to 21.

During this same period of time, Saint Anthony Medical Center ("St. Anthony"), another hospital located in Rockford, Illinois, similarly had an agreement with the University concerning the Family Practice Residency Program. The Intermediary audited St. Anthony's FTE base year of September 30, 1996 and established an FTE resident cap of 6.42 FTE residents for the IME program and 8.42 FTE residents for GME program.[22] The Provider's resident rotation schedules and IRIS reports for the September 30, 1996 fiscal year end[23] reflect this resident count.

In June of 1996 St. Anthony Medical Center withdrew from the residency program. St. Anthony did not claim any FTEs for training interns and residents after its September 30, 1996 cost report. In addition, St. Anthony was not listed as a participant in the Family Practice Residency Program in the ACGME Directory after the 1995-1996 academic year.[24]

The residents that were a part of the St. Anthony program were absorbed by the Provider's residency program. After the Provider added the former St. Anthony's residents, the Provider contacted the Intermediary and was told to adjust its GME and IME FTE resident caps upward to reflect these additional residents. The Provider's NPR's for FYs 1998 through 2003 reflected this increase. In February 2005, the Intermediary reopened the cost reports for FYs 1999 through 2003, adjusting the Provider's FTE resident caps downward to omit the St. Anthony residents.[25] It is the FTE resident cap adjustments for these St. Anthony residents that are at the core of this appeal.

In 2005, the Provider timely filed an appeal with the Board challenging the Intermediary's reduction of its 1996 base year FTE resident IME/GME counts. A hearing was held before the Board, and on June 30, 2008, the Board issued a decision in favor of the Intermediary. The Board found the Provider's FTE counts were properly adjusted and that the Provider did not meet any of the various requirements of the Medicare regulations that would have allowed it to include additional FTEs in its counts.[26]

In November 2008, the Provider filed suit in the U.S. District Court for the District of Columbia alleging that the Board's decision violated the Administrative Procedure Act, 5 U.S.C. §§ 701 *et seq.* On March 29, 2011, in response the parties Motions for Summary Judgment, the U.S. District Court ruled:

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[21] *See* Intermediary Exhibit I-2. This resident count is reflected in the Provider's resident rotation schedules for FY 1996 included at Provider Exhibit P-49, pages 17 to 21.
[22] *See* Intermediary Exhibit I-3.
[23] *See* Intermediary Exhibit I-20.
[24] *See* Intermediary Exhibit I-26.
[25] The Intermediary later reopened cost reports and adjusted FTE resident caps downward for FYEs 2003-2008. *See* Provider's Brief in Support of Its Position at 6.
[26] *See Swedish Am. Hosp. v. Mutual of Omaha Ins. Co.,* PRRB Dec. No. 2008-D45 (Sept. 30, 2008).

1) The Secretary cannot be estopped from recovering Medicare funds provided to the Provider based on erroneous advice provided by the Intermediary;

2) The Board's decision does not contravene Congress's intent; and

3) Although the Board reasonably decided that the Affiliated Group Exception did not apply, it was arbitrary not to address whether the Temporary Cap Increase Exception applied.[27]

The Court remanded the case back to the Board for further analysis and explanation regarding why the Temporary Cap Increase Exception does not apply to the Provider's case.[28] Both parties have filed briefs in support of their positions.

The Provider was represented by Charles F. MacKelvie, Esq., of Krieg Devault, LLP. The Intermediary was represented by Arthur E. Peabody, Jr., Esq., of the Blue Cross and Blue Shield Association.

PROVIDER'S CONTENTIONS:

The Provider contends the Temporary Cap Increase Exception applies to this case, and that HCFA (the predecessor to CMS) was wrong in its development of the law and prior decisions in this case. The Provider maintains that Congress never intended to permanently reduce the number of aggregate FTE resident caps for teaching hospitals if a hospital discontinues its residency program. The Provider disputes CMS' logic regarding the discontinued residency program, arguing that retaining resident slots in the discontinued Program for perpetuity makes absolutely no sense. Accordingly, the Provider concludes that CMS was wrong in its interpretation and enforcement of the law.[29]

The Provider states that because, St. Anthony did not claim any residents or GME/IME costs on any of its cost reports since 1996, and that beginning July 1, 1996, the Provider claimed the same number of residents (approximately 23.5 for GME purposes and 15.05 for IME purposes) that the Provider and St. Anthony had been collectively claiming in FYEs 1994 and 1995. The Provider asserts that, consistent with the August 1997 Final Rule, there has been no net increase in the cost (other than inflation) to the Medicare program from Swedish assuming total sponsorship of the residency program in its 1997 and subsequent cost reports.[30]

At a minimum, the Provider argues that the Temporary Cap Exception applies to the years at issue. Further, allowing a hospital that takes on displaced students to permanently increase its FTE resident cap is consistent with the goal of the Medicare regulations to remove a significant

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[27] *See* Swedish Am. Hosp. v. Sebelius, 773 F. Supp. 2d 1 (D.D.C. 2011), *denied recons.*, 845 F. Supp. 2d 245 (D.D.C. 2012).
[28] *See id.* at 8-14.
[29] *See* Provider's Brief in Support of its Position at 12-13.
[30] *See id.* at 14-15.

barrier that might prevent hospitals from assisting residents who are suddenly displaced from their original training site and allowing them to complete their Residency Program.[31]

Finally, the Provider argues that the Secretary confirmed in the May 1998 Final Rule that adjustment of a hospital's FTE resident cap would be appropriate in situations where the hospital assumed residents who were displaced because another hospital closed its teaching program. As the May 1998 Final Rule did not clearly articulate regulations or other guidance regarding when such an upward adjustment would be appropriate, the Provider sought and reasonably relied on guidance it received from the Intermediary that an upward adjustment for its FTE resident cap was appropriate to account for the displaced residents it absorbed from St. Anthony.[32]

The Provider requests that its FTE resident cap be increased to allow it to be reimbursed for 3 residents per year that joined and completed the Program for FYs 1999 through 2003. In the alternative, the Provider requests that it be paid for the 3 former St. Anthony residents Swedish educated in FYs 1999 and 2000.[33]

INTERMEDIARY'S CONTENTIONS:

At the outset, the Intermediary notes that, on July 1, 1996, ACGME acknowledged it had ceased to approve St. Anthony's 3-year residency program, and St. Anthony had residents that were displaced as of July 1, 1996. Accordingly, the Intermediary contends that any displaced residents trained by another hospital should have completed their training by June 30, 1999.

The Intermediary contends the May 1998 Final Rule addressing the Temporary Cap Increase Exception and applicable at that time only applied to residents that were displaced through the closure of a hospital. Since the residents from St. Anthony's were displaced due to the closure of the residency program only, the May 1998 Final Rule does not apply.[34]

The Intermediary further asserts that the August 2001 Final Rule extended the temporary FTE resident cap increase to those hospitals that added residents due to the closure of another hospital's program, but that this rule only became effective for fiscal years beginning on and after October 1, 2001. The Intermediary argues that this 2001 Rule does not apply in this case because those residents displaced from the closure of the St. Anthony's program would have completed their training several years prior to October 1, 2001.[35]

Base on the above, the Intermediary concludes that the Provider does not meet the requirements to receive the Temporary Cap Increase Exception.

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[31] *See id.* at 15-18.
[32] *See id.* at 18-19. *See also* Provider's letter to the Board dated June 9, 2014.
[33] *See id.* at 20.
[34] *See* Intermediary's Response to Provider's Brief at 1.
[35] *See id.*

FINDINGS OF FACT, CONCLUSION OF LAW AND DISCUSSION:

After considering the Medicare law and guidelines, parties' contentions and evidence submitted, the Board finds and concludes that Provider does not meet the requirements to receive the Temporary Cap Increase Exception for FYs 1999 through 2003.

The Temporary Cap Increase Exception is allowed in order to assist displaced residents to complete their education program.[36] Based on its review of the record, the Board finds the displaced residents from St. Anthony's program were in a three year training program.[37] As a result, the temporary FTE resident cap increase to assist the residents to complete their education, if applicable, would have applied only to the residency years ended June 30, 1997 through June 30, 1999 for any residents that the Provider absorbed as of September 30, 1996. Therefore, there are only two fiscal years at issue in this appeal to which the Temporary Cap Increase Exception could possibly apply – FYs 1999 and 2000. The other fiscal years are outside the relevant residency time period.

Regarding FYs 1999 and 2000, the Board finds the "Temporary Cap Increase Exception" promulgated as part of the May 1998 and July 1999 Final Rules applied *only* to residents that were displaced through the closure of a hospital.[38] In the preamble to May 1998 Final Rule, CMS recognized that displaced residents can occur when a "hospital closes or discontinues its [residency] program." However, in that preamble, CMS only provided one situation in which it "will allow" for temporary adjustments to a hospital's FTE resident cap, namely "to reflect residents affected by a *hospital closure*" during the July 1996-June 1997 residency year if certain specified criteria were met. As explained in the preamble to the July 1999 Final Rule, CMS expanded this limited policy to include hospital closure occurring during subsequent years:

> Under current policies, we permit a temporary adjustment to the FTE [resident] cap for a hospital only if it assumed additional medical residents *from a hospital that closed* in the July 1996–June 1997 residency training year. We are proposing to allow adjustments to address *hospital closures after this period.* Thus, we would allow an adjustment for a hospital if it takes on additional residents *from a hospital that closes* at any time on or after July 1, 1996. This adjustment is intended to account for residents who may have partially completed a medical residency training program and would be unable to complete their training without a residency position at another hospital.[39]

This version of the Temporary Cap Increase Exception was in effect from June 1998 through September 30, 2001. The Board finds that it is uncontested that St. Anthony's did not close its

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[36] *See* 63 Fed. Reg. at 26330; 42 C.F.R. § 413.86(g)(8) (1999); 42 C.F.R. §§ 413.86(g)(8), 412.105(f)(1)(ix) (2001); 66 Fed. Reg. at 39899-39901.
[37] *See* Transcript at 87.
[38] *See* 63 Fed. Reg. at 26330; 64 Fed. Reg. at 41490, 41522; 42 C.F.R. § 413.86(g)(8) (1999).
[39] 64 Fed. Reg. at 41521 (emphasis added). *See also* 64 Fed. Reg. 24716, 24736 (May 7, 1999) (proposed rule includes the same statement *verbatim*).

hospital (*i.e.*, terminate participation in the Medicare program); rather, it only closed the residency training program. The regulation applicable to this period defines a "closure" as follows: "(iii) For purposes of paragraph (g)(8) of this section, 'closure' means the hospital terminates its Medicare agreement under the provisions of § 489.52 of this chapter."[40] The Board finds the Provider does not qualify under the May 1998/July 1999 version of the Temporary Cap Increase Exception because St. Anthony's closure/discontinuance of its residency training program does not meet the hospital "closure" requirement as defined by § 413.86(g)(8)(iii) for the period prior to October 1, 2001.[41]

The Board recognizes that the August 2001 Final Rule expanded the "Temporary Cap Increase Exception" for closure of another hospital's program, without the requirement that the hospital itself be closed.[42] However, this expansion in the regulation was effective only for direct GME for *cost reporting periods* beginning on or after October 1, 2001 and for IME with *discharges* beginning on or after October 1, 2001.[43] Accordingly, the Board finds that this expansion in the regulation is not applicable because any of the displaced residents would have completed their training prior to October 1, 2001.

The Board's finding is consistent with the following discussion in the preamble of the August 2001 Final Rule that provides an example:

> Finally, we proposed that hospitals that meet the proposed criteria would be eligible to receive temporary adjustments (for cost reporting periods beginning on or after October 1, 2001, for direct GME and with discharges beginning on or after October 1, 2001 for IME) for training the displaced residents from programs that closed even before the effective date of this policy. We mention this because hospitals may have closed programs in the recent past and residents from the closed programs may not have completed their training as of the effective date of this policy. For instance, if a 5-year residency program, such as surgery, closed on July 1, 1997, the 5th program year residents may still be training during this residency year (2001). We proposed that if both the receiving hospital(s) and the hospital that closed the program in this example follow the criteria described in this preamble, the receiving hospital may receive a temporary adjustment to its FTE [resident] cap for 9 months (October 1, 2001 through June 30, 2002) to

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[40] 42 C.F.R. § 413.86(g)(8)(iii) (1999).

[41] This finding is further supported by the fact that the May 1998 Final Rule distinguishes between a hospital closure and discontinuing or closing a residency program and only specifies that CMS "will allow" for a temporary FTE resident cap adjustment when there is "a hospital closure." 63 Fed. Reg. at 26330. Accordingly, based on this distinction, the consistent use of the term "hospital closure" in the May 1998 and July 1999 Final Rules, and the regulatory definition of "closure" promulgated in the July 1999 Final Rule, the Board must conclude that, contrary to the Provider's contention, a "hospital closure" as used in the May 1998 Final Rule could not include discontinuing or closing a residency program.

[42] *See* 66 Fed. Reg. at 39899-39901.

[43] *See id.* at 39828, 39899-39901. *See also* 42 C.F.R. §§ 413.86(g)(8), 412.105(f)(1)(ix) (2001).

> accommodate the 5th year residency students. However, we noted that hospitals would not be eligible to receive a temporary adjustment for training the residents until the effective date of this rule (that is, October 1, 2001).[44]

CMS' response to a comment further highlights that a temporary FTE resident cap increase was not intended to be a permanent FTE resident cap increase to the receiving hospital. The commenter questioned whether the receiving hospital would be "penalized" because of the way in which the FTEs were calculated. In response, CMS stated that it is revising the proposed regulation, adding a paragraph which specifies that "FTE residents that are displaced by the closure of . . . another hospital's program are added after the calculation of the rolling average for the receiving hospital *for the duration of time that those displaced FTE residents are training at the receiving hospital.*"[45] The Board believes that its decision to disallow the application of the Temporary Cap Exception in this case is consistent with the examples and stated principles articulated in the 2001 Final Rule.

DECISION AND ORDER:

The Temporary Cap Increase Exception does not apply to the Provider's resident FTE resident cap for FYs 1999 through 2003. .

BOARD MEMBERS PARTICIPATING:

Michael W. Harty, Chairman
John Gary Bowers, C.P.A.
Clayton J. Nix, Esq.
L. Sue Andersen, Esq.

FOR THE BOARD:

Michael W. Harty
Chairman

DATE: JUL 09 2014

[44] 66 Fed. Reg. at 39899-39900.
[45] *Id.* at 39900-39901 (emphasis added).