PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

ON THE RECORD
2018-D5

PROVIDER–
Kindred 2006-2014 LTCH/SNF Bad Debts CIRP Groups

Provider No.: Appendix A

vs.

MEDICARE CONTRACTOR –
Wisconsin Physicians Service

DATE OF RECORD HEARING -
April 13, 2017

Cost Reporting Periods Ended -
2006-2014

CASE NOs.: 08-0585GC; 09-1589GC; 10-0090GC; 11-0028GC; 12-0147GC; 13-2822GC; 14-1622GC; 15-3239GC and 16-1252GC

INDEX

ISSUE STATEMENT:

Whether the Providers may be reimbursed for bad debts incurred by patients who were dually eligible for Medicare and Medicaid.[1]

DECISION:

After considering the law and program instructions, the evidence presented, and the parties' contentions, the Provider Reimbursement Review Board ("Board") affirms the Medicare Contractor's dual eligible bad debt adjustments for the Providers that chose not to enroll in the Medicaid programs in Massachusetts, Tennessee, and Pennsylvania beginning in 2012. The Board reverses the Medicare Contractor's dual eligible bad debt adjustments where the state's Medicaid program (Pennsylvania prior to 2012) would not enroll Long Term Care Hospitals (LTCHs) and remands those claims back to the Medicare Contractor to determine the appropriate amount of bad debt reimbursement.

INTRODUCTION:

These appeals involve nine LTCHs and one skilled nursing facility ("SNF") (collectively referred to as "Providers") affiliated with Kindred Healthcare, Inc. ("Kindred") for various cost reporting years between 2006 and 2014.[2] The Kindred LTCHs are located in Massachusetts and Pennsylvania and the Kindred SNF is located in Tennessee. None of the Kindred Providers were enrolled as Medicaid providers in their respective states during the cost reporting periods at issue.[3]

The Providers' Medicare Contractor, Wisconsin Physicians Service ("Medicare Contractor") denied Kindred's bad debt claims for individuals who were eligible for both Medicare and Medicaid services (referred to as "dual eligibles") based on the Centers for Medicare & Medicaid Services' ("CMS'") "must bill" policy. This policy requires providers to bill the relevant state Medicaid program for Medicare deductibles and copayments and receive a remittance advice ('RA") denying payment (in whole or in part) before the uncollectable amount can be reimbursed as a Medicare bad debt.[4]

The Kindred LTCHs and SNF timely appealed the denial of their bad debt reimbursement to the Board and met the jurisdictional requirements for a hearing. The Board conducted a hearing on the record. Glenn P. Hendrix, Esq., of Arnall Golden Gregory, LLP represented the Providers. Jerrod Olszewski, Esq. of the Federal Specialized Services represented the Medicare Contractor.

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[1] Providers' Final Position Paper at 1.
[2] *Id. See* Appendix A for Schedules of Providers. Note: Case # 16-1252GC for 2014 was added to the record hearing by letter dated March 16, 2016.
[3] Stipulations dated January 15, 2016 at ¶ 4.
[4] Medicare Contractor's Revised Final Position Paper at 9 and Stipulations at ¶ 8.

STATEMENT OF THE FACTS:

A. MEDICARE'S BAD DEBT POLICY

Medicare regulations governing bad debts are located at 42 C.F.R. § 413.89 (2004).[5] Subsection (a) establishes the general rule that bad debts are deductions from revenue and are not to be included in allowable costs. However, in order to ensure that Medicare-covered costs are not shifted to individuals who are not covered by the Medicare program, subsection (d) specifies that bad debts attributable to Medicare deductibles and coinsurance are reimbursable as allowable costs. Bad debts must meet the following criteria specified in subsection (e) to be considered allowable:

(1) The debt must be related to covered services and derived from deductible and coinsurance amounts.
(2) The provider must be able to establish that reasonable collection efforts were made.
(3) The debt was actually uncollectible when claimed as worthless.
(4) Sound business judgment established that there was no likelihood of recovery at any time in the future.

CMS has provided extensive guidance on its bad debt policy in the Provider Reimbursement, Manual, CMS Pub. No. 15-1 ("PRM 15-1"), §§ 308, 310, 312 and 322. PRM 15-1 § 308 requires that the provider make reasonable collection efforts and apply sound business judgment to determine that the debt was actually uncollectible. PRM 15-1 § 310 states that a "reasonable collection effort" involves the issuance of a bill on or shortly after discharge or death….[6] However, this section by its own terms, is inapplicable to indigent patients and specifically refers to § 312 which allows providers to "deem Medicare beneficiaries indigent or medically indigent when such individuals have also been determined eligible for Medicaid as either categorically needy individuals or medically needy individuals, respectively."[7] While this language absolves the providers from taking further steps to prove the dual eligible patient indigent, subsection C of § 312 requires providers to "determine that no source other than the patient would be legally responsible for the patient's medical bill; e.g., title XIX, local welfare agency and guardian..."[8]

Finally, PRM-I § 322 states that a provider may not claim Medicare bad debt reimbursement for that portion of the deductible and copayment amounts that "the State is obligated either by statute or under the terms of its plan to pay all, or any part, of the Medicare deductible or coinsurance amounts" but may claim the "portion of deductible or coinsurance amounts that the State is not obligated to pay" provided that the requirements of § 312 or, if applicable § 310 are met.

On August 10, 2004, CMS issued the Joint Signature Memorandum ("JSM") JSM-370 to Medicare contractors to clarify and explain its "must bill" policy that the provider must bill and

[5] Redesignated from 42 C.F.R. § 413.80 pursuant to 69 Fed. Reg. 48916, 49254 (Aug. 11, 2004).
[6] PRM 15-1 § 310.
[7] PRM 15-1 § 312.
[8] PRM 15-1 § 312 at 3.

obtain an RA from the relevant state Medicaid program whenever a bad debt involves a dual eligible for whom the program owes nothing or a portion of the dual eligible's Medicare deductible or co-payment.[9] The Ninth Circuit, in *Community Hosp. of the Monterey Peninsula v. Thompson* ("*Monterey*"),[10] found that CMS' must-bill policy was reasonable and not inconsistent with the statute and regulations governing fiscal years 1989 through 1995.[11] In a subsequent case, *Cove Associates Joint Venture v. Sebelius*, the D. C. District Court also upheld the agency's must bill policy but noted that a provider that was unable to bill the state Medicaid program because it could not be enrolled as a Medicaid provider was caught in a "Catch-22" and remanded the case back to the agency to determine whether the providers were justified in relying on CMS' prior failure to enforce the must-bill policy with respect to dual-eligible reimbursement claims from non-participating Medicaid providers.[12]

B. MEDICARE BAD DEBTS ASSOCIATED WITH STATE COST SHARING OBLIGATIONS FOR DUAL ELIGIBLES

State Medicaid agencies have a legal obligation to reimburse providers for any Medicare cost-sharing (Medicare deductibles and copayments) on behalf of poor and low-income Medicare-eligible individuals. While a state may limit payment of cost sharing amounts for most dual eligible patients,[13] a state may be obligated to pay full cost sharing amounts for patients who qualify for Medicaid as Qualified Medicare Beneficiaries ("QMBs").[14]

In general, to receive Medicaid reimbursement, a provider must enroll as a Medicaid provider. Some state Medicaid agencies do not allow enrollment of certain providers (*e.g.*, CMCHs, long term care hospitals, inpatient rehabilitation facilities) and, in those situations, the providers are unable to bill the state Medicaid program for Medicare cost sharing amounts. The Kindred Providers were not enrolled as Medicaid providers during the time periods at issue.[15] The parties

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[9] JSM-370 may be found at Provider Exhibit P-5. Specifically, JSM 370 states:

> The must bill policy states that if a patient is determined by the provider to be indigent or medically indigent, the provider does not need to attempt to collect from the patient. However, the provider must make certain that "no source other than the patient would be legally responsible for the patient's medical bill; e.g. title XIX, local welfare agency . . . ." prior to claiming the bad debts from Medicare. . . . in those instances where the state owes none or only a portion of the dual eligible patient's deductible or co-pay, the unpaid liability for the bad debt is not reimbursable to the provider by Medicare until the provider bills the State, and the State refuses payment (with a State Remittance Advice).
> (citations omitted.)

[10] 323 F.3d 782, 785 (9th Cir. 2003).

[11] However, with respect to the time under review, the Court declined to apply § 1102.3L which was added to PRM 15-2 in 1995 to allow for certain documentation as an alternative to RAs. In CMS Memorandum, JSM-370, CMS withdrew § 1102.3L and reverted back to the pre-1995 language which required providers to bill state Medicaid programs before claiming Medicare bad debt.

[12] *848 F.Supp.2d 13, 30 (D.D.C.* 2012).

[13] 42 U.S.C. § 1396a(n)(2) allows states to limit the cost-sharing amount to the Medicaid rate and "essentially pay nothing toward the dual eligibles' cost sharing if the Medicaid rate is lower than what Medicare would pay for the service."

[14] However, 42 U.S.C. §1396d(p)(3), at least for a time, required state Medicaid programs to pay cost-sharing amounts for QMBs.

[15] Stipulations at ¶ 4.

dispute whether the Providers had to bill the state Medicaid programs and receive RAs to receive Medicare bad debt reimbursement.

DISCUSSION, FINDINGS OF FACT, AND CONCLUSIONS OF LAW

The Kindred LTCHs and SNF contend that prior to 2005, the Medicare Contractor did not require non-Medicaid-participating providers to bill the state for Medicare cost-sharing amounts and obtain RAs from the state in order to be reimbursed for bad debt.[16] Rather the Medicare Contractor accepted proof of a beneficiary's indigence as a sufficient basis for Medicare bad debt reimbursement.[17] The Providers point out that the Medicare Contractor reversed this policy when settling their FYs 2006 – 2014 cost reports, using the "must bill" policy to require that both participating and non-participating Medicaid providers bill the state Medicaid programs, and obtain RAs before claiming Medicare bad debt. The Kindred Providers argue that applying CMS' "must bill" policy violates the Bad Debt Moratorium."[18] Further the Kindred Providers maintain that the Medicare Contractor's denial of the bad debt claims at issue is unsupported by statute or regulation and is arbitrary and capricious.[19]

The Kindred Providers also assert that CMS has recognized some exceptions to its "must bill" policy for community mental health centers ("CMHC") and Institutes for Mental Diseases ("IMD").[20] The Kindred Providers argue that the rationale for CMHCs and IMDs is equally applicable in this case because, similar to CHMCs and IMDs, many state Medicaid programs do not recognize and certify LTCHs as providers and, therefore, will neither enroll them, process their Medicaid claims, nor issue RAs to them. The Kindred Providers also argue that an exception to the "must bill" policy must apply to providers who simply choose not to participate in their state Medicaid program.[21]

Finally, the Kindred Providers contend that they satisfied the requirement of submitting bills for the fiscal years at issue and that they could not obtain RAs because the state Medicaid program simply refused to process the claims of a non-Medicaid participating provider. The Kindred Providers contend they are in the same situation as the providers in *Cove Associates*[22] where the district court found a classic "Catch 22" situation putting providers in the untenable position of either refusing to treat dual eligible patients or absorbing the bad debts associated with those patients. As a result, the Kindred Providers contend that they were forced to bear the costs of allowable Medicare bad debts, in violation of Medicare's statutory prohibition on cost shifting.[23]

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[16] Providers' Final Position Paper at 11.

[17] Providers' Final Position Paper at 11, 19. In further support of the position that CMS did not require non-Medicaid-participating providers obtain an RA, the Kindred Providers cite to the 1995 instructions for completing CMS Form 339 (copy included at Provider Exhibit P-4). In particular, the 1995 instructions addressing bad debts required only that the provider furnish documentation of Medicaid eligibility and proof that non-payment would have resulted from the billing.

[18] Providers' Final Position Paper at 25.

[19] Providers' Final Position Paper at 14, 20.

[20] See Select Specialty '05 Medicare Dual Eligible Bad Debt Group vs. Wisconsin Physician Serv, PRRB Dec. 2010-D-25 (April 13, 2010) *rev'd* by CMS Adm'r, CCH 82,605 (June 9, 2010).

[21] Providers' Final Position Paper at 9.

[22] *Cove Assocs. Jt. Venture v. Sebelius ("Cove*") 848 F. Supp. 2d 13, 28 (D.D.C. 2012).

[23] Providers' Final Position Paper at 28; 42 U.S.C.§ 1395x(v)(1)(A)(i).

For its part, the Medicare Contractor maintains that Medicare regulations require providers to maintain sufficient financial records and statistical data for proper determination of costs payable under the program.[24] The Medicare Contractor states that the "must bill" policy is a reasonable reading of the regulations that has been upheld by the Administrator and the courts.[25] The Medicare Contractor contends that the Providers had not submitted "invoices" to the state Medicaid agencies until after the subject bad debts were removed from the cost reports.[26]

The Medicare Contractor believes it is irrefutable that the Providers claimed the bad debts as worthless prior to determining that no other source other than the patient would be legally responsible for the patients' medical bills. The Medicare Contractor asserts that the Providers have accepted the patients as "indigent" simply because they were Medicaid beneficiaries. However, no RAs were submitted as evidence to confirm the States' lack of responsibility for payment.[27]

Having considered the positions of the parties, the evidence presented and the statutory and regulatory authority, the Board finds CMS' pre-1987 bad debt policy clearly established that providers have an obligation to bill "the responsible party." Three federal appeals courts have reviewed CMS' "must bill" policy and while none of the decisions applied the Bad Debt Moratorium, they are still instructive as to CMS' policy at the time. Specifically the First Circuit concluded that "some version" of a "must bill" policy has generally been enforced and that a general requirement (as opposed to a *per se* requirement) to obtain a Medicaid RA for crossover claims is entitled to deference where "the Secretary has made exceptions and accepted alternative documentation *from the State* where circumstances warranted the exception."[28] Similarly, the D.C. Circuit found that it is "sensible for the Secretary to require that the state determine in the first instance the Medicaid eligibility of the claims and the appropriate amount of state payment owed…"[29] Finally, the Ninth Circuit deferred to the Secretary's reasonable determination that "the must bill policy is a 'fundamental requirement to demonstrate'… that reasonable collection efforts [have been] made and that 'the debt was actually uncollectible when claimed [as worthless]."[30]

A. STATES IN WHICH THE KINDRED LTCHS AND SNF COULD BE CERTIFIED AS MEDICAID PROVIDERS BUT DID NOT ENROLL.

The record before the Board shows that the Kindred LTCHs and SNF could have enrolled in the state Medicaid programs in Massachusetts,[31] Tennessee,[32] and beginning in 2012,

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[24] 42 C.F.R. § 413.20(a).
[25] Medicare Contractor Final Position Paper at 9.
[26] Medicare Contractor's Final Position Paper at 10. Also see Exhibit P-8 for Kindred Hospital North Shore's 2006 invoices dated June 30, 2008.
[27] Medicare Contractor Final Position Paper at 15.
[28] *Maine Med. Ctr. v. Burwell*, 775 F. 3d 470, 475, 480 (1st Cir. 2015) (emphasis in original).
[29] *Grossmont Hosp. Corp v. Burwell* 797 F. 3d 1079, 1085 (D.C. Cir. 2015), *reh'g en banc denied* (D.C. Cir. 2015).
[30] *Community Hosp. of Monterey Peninsula v. Thompson*, 323 F.3d 782, 792, 796 (9th Cir. 2003).
[31] Stipulations dated January 15, 2016 at ¶ 6 stating Massachusetts Providers could have enrolled in the Massachusetts Medicaid Program as an acute inpatient hospitals.
[32] Stipulations at ¶ 7.

Pennsylvania.[33] For the States allowing LTCH and SNF enrollment, the Kindred Providers had no excuse for not enrolling as a Medicaid provider and obtaining a Medicaid billing number. The Kindred Providers' decision *not* to enroll in a particular state Medicaid program was a business decision.

As previously discussed, PRM 15-1 § 322 confirms that, if the Medicaid State plan provides for payment of Medicare coinsurance and deductibles (in whole or in part), then the amount of the payment cannot be allowable as Medicare bad debt. Significantly, this is a blanket requirement that it not predicated on whether the provider does or does not participate in the relevant Medicaid program.[34] Second, this excerpt cross-references the requirements of § 310 confirming that, *at a minimum*, the § 310 requirement to "bill . . . the party responsible" is applicable to crossover claims (i.e., claims involving dual eligibles and QMBs).[35]

Notwithstanding the § 322 need to determine whether the relevant state's Medicaid program was "responsible," the Kindred LTCHs and SNF made business decisions not to enroll in the state's Medicaid program and have not submitted any documentation (whether in the form of RAs or other evidence[36]) that confirms the state's Medicaid program is not responsible for Medicare coinsurance and deductibles of dual eligibles or QMBs. Further, as previously noted, PRM § 322 pre-dates and complies with the Bad Debt Moratorium.[37]

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[33] See Exhibit P-1 and stipulations dated January 15, 2016 at ¶ 5.

[34] *See also Cove Assocs. Jt. Venture v. Sebelius*, 848 F. Supp. 2d 13, 25 (D.D.C. 2012).

[35] The Board recognizes that CMS issued a transmittal in November 1995 revising cost reporting instruction on bad debt documentation to allow providers "in lieu of billing" to submit alternative documentation to establish that nonpayment would have occurred if the crossover claim had been billed. *See* PRM 15-2, Ch. 11, Transmittal No. 4 (Nov. 1995) (revising PRM 15-2 § 1102.3). However, the Board notes that this decision does *not* opine on whether this 1995 transmittal does or does not violate the Bad Debt Moratorium (*i.e.*, whether that portion of CMS' "must bill" policy that requires billing of crossover claims even when nonpayment would have occurred if the crossover claim had been billed violates the Bad Debt Moratorium) because neither this sub-issue nor this transmittal are relevant to deciding the issues in this case.

[36] The Kindred Providers point to the 1995 bad debt instructions for the CMS Form 339 to support their position that an RA is not required yet they did not comply with those instructions. These instructions specify that, "to establish that Medicaid is not responsible for payment," the provider may, in lieu of billing, furnish documentation of Medicaid eligibility and proof that "non-payment would have occurred if the . . . claim had been filed with Medicaid." However, the Kindred LTCHs and SNF have not furnished any evidence that the States allowing LTCH and SNF enrollment are not responsible for payment under the state Medicaid plan had a claim been filed. As the Kindred LTCHs and SNF have not submitted evidence to demonstrate that the States allowing LTCH and SNF enrollment had no responsibility for coinsurance and deductibles, the Board need not address: (1) whether this other documentation would be acceptable; or (2) whether the CMS' position that the "must bill" policy necessarily includes obtaining an RA from a state even when that state has no responsibility violates the Bad Debt Moratorium.

[37] In support of its position, the Board notes the following examples of pre-1987 agency statements and Board cases applying CMS' bad debt policy: HCFA Action No. HCFA-AT-77-73 (MMB) (July 5, 1977) (responding to questions about a change in federal law in January, 1968 which made payment of Medicare deductible and copayments by the state Medicaid program optional); *Geriatric and Med'l Ctrs., Inc. v. Blue Cross Ass'n,* PRRB Dec. No. 82-D62 (Mar. 3, 1982) (finding that "the cost of these services were not included in payments for services covered by the State of Pennsylvania"), *decl'd* review, HCFA Adm'r (Apr. 23, 1982); *Concourse Nursing Home Grp. Appeal v. Travelers Ins. Co.*, PRRB Dec. No. 1983-D152 (Sept. 27, 1983) (finding that "the Provider has furnished no documentation which would support its contentions that it had established collection policies and procedures or that actual collection efforts were made to obtain payments from the patients or the Medicaid authorities before an account balance was considered . . . bad debt"), *decl'd review*, HCFA Adm'r (Nov. 4, 1983); *St. Joseph Hospital v. Blue Cross Blue Shield Ass'n*, PRRB Dec. No. 84-D109 (Apr. 16, 1984) (finding that "the

As a result, the Kindred Providers cannot demonstrate their compliance with the requirement to determine that "no other source other than the patient would be legally responsible for the patient's medical bill…" as is required by Medicare bad debt policy.[38] The Board concludes that the Medicare Contractor's disallowance of the Kindred Providers' bad debt was proper as it relates to the Massachusetts, Tennessee, and beginning in 2012 Pennsylvania.

B. States in Which the Kindred LTCHs Could Not Be Certified as Medicaid Providers.

The Board's review of the record, shows that LTCHs in the state of Pennsylvania prior to 2012, were unable to enroll in the state's Medicaid program and, therefore, were unable to bill the Pennsylvania Medicaid program. At that time Pennsylvania did not recognize nor reimburse LTCHs, including but not limited to the Kindred LTCHs. This is similar to the exception to the must bill policy that CMS recognized for CMHCs in *Monterey*.

Moreover, these Kindred LTCHs clearly appear to be caught in a "Catch-22" as identified by the D.C. District Court in *Cove*. Like the LTCHs in *Cove*, the Kindred LTCHs were told to comply with the Medicare "must bill" policy even though they were unable to do so because billing privileges for the Pennsylvania Medicaid program was contingent on enrollment in that program and, as LTCHs, they could not enroll in the state Medicaid program. In *Cove*, the Secretary's position was that "states are required to issue RAs (regardless of a provider's participation status)" although the agency's counsel conceded "it was in a better position than the providers to ensure that the states comply." However, the *Cove* Court was "not willing to place a stamp of judicial approval on a policy that would put non-participating providers in the position of not being paid due to the delinquency of federally-funded state programs."[39]

Based on *Cove*, the Board finds that the Medicare Contractor improperly disallowed dual eligible bad debt reimbursement for Kindred's Pennsylvania LTCHs prior to 2012. Accordingly, the Board reverses the Medicare Contractor's dual eligible bad debt adjustment for periods prior to 2012 for the Kindred LTACs located in Pennsylvania, and remands these cost reports to the Medicare Contractor to determine the appropriate amount of bad debt reimbursement.

DECISION AND ORDER

After considering the law and program instructions, the evidence presented, and the parties' contentions, the Board affirms the Medicare Contractor's dual eligible bad debt adjustments for Providers that chose not to enroll in the Medicaid programs in Massachusetts, Tennessee, and beginning in 2012 Pennsylvania. The Board reverses the Medicare Contractor's dual eligible bad debt adjustments where the state's Medicaid program (Pennsylvania - prior to 2012) would not enroll a LTCH, and remands those claims back to the Medicare Contractor to determine the appropriate amount of bad debt reimbursement.

Provider did not attempt to bill the State of Georgia for its Medicaid patients"), *decl'd review*, HCFA Adm'r (May 14, 1984).

[38] PRM 15-1 Chapter 3 § 312.

[39] *Cove Assocs. Jt. Venture v. Sebelius* 848 F. Supp. 2d 13, 28 (D.D.C. 2012).

BOARD MEMBERS PARTICIPATING

L. Sue Andersen, Esq.
Charlotte F. Benson, CPA
Gregory Ziegler, CPA, CPC-A

FOR THE BOARD:

/s/
L. Sue Andersen
Chairperson

DATE: November 20, 2017

APPENDIX A
SCHEDULE OF PROVIDERS

SCHEDULE OF PRRB PROVIDERS: BAD DEBTS

Page No. 1 of 1

Group Name Kindred 06 LTCH/SNF Bad Debts

Date Prepared April 2, 2008

Representative Tracy M. Field, Arnall Golden & Gregory

Issue Bad Debt: Must Bill

Case No. 08-0585G

				A	B	C	D	E	F	G
Provider No.	Provider Name	FYE	Intermediary	Date of Final Determination	Date of Hearing Request	Number of Days	Audit Adjustment Number	Approx. Amount (in $'s)	Original Case No. (if any)	Date of Add/ Transfer
22-2044	Kindred Hospital Boston North Shore Peabody, Essex County, MA	08/31/06	WPS Health Insurance	12/21/07	3/4/08	74	10, 11, 12	$121,206	N/A.	N/A
22-2045	Kindred Hospital Boston Boston, Suffolk County, MA	08/31/06	WPS Health Insurance	1/11/08	3/4/08	53	15	$291,784	N/A	N/A
39-2027	Kindred Hospital Philadelphia Philadelphia, Philadelphia County, PA	08/31/06	WPS Health Insurance	12/31/07	3/4/08	64	13, 14	$67,670	N/A	N/A
39-2032	Kindred Healthcare Delaware Darby, Delaware County, PA	08/31/06	WPS Health Insurance	1/2/08	3/4/08	62	16	$102,796	N/A	N/A
39-2043	Kindred Hospital Heritage Valley Beaver, Beaver County, PA	06/30/06	Mutual of Omaha Insurance	8/3/07	1/10/08	160	10	$45,126	N/A	N/A
44-5140	Primacy Healthcare & Rehab Memphis, Shelby County, TN	06/30/06	Mutual of Omaha Insurance	11/2/07	1/10/08	69	2	$83,044	N/A	N/A

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SCHEDULE OF PRRB PROVIDERS: BAD DEBTS

Group Name Kindred 07 Bad Debts Appeals

Page No. 1 of 1

Representative Tracy M. Field, Arnall Golden & Gregory

Date Prepared December 11, 2009

Case No. 09-1589GC

Issue Bad Debt: Must Bill

				A	B	C	D	E	F	G
Provider No.	Provider Name	FYE	Intermediary	Date of Final Determination	Date of Appeal	Number of Days	Audit Adj. No.	Amount in Controversy (Reimbursement Effect)	Original Case No. (if any)	Date of Add/ Transfer
39-2027	Kindred Hospital Philadelphia Philadelphia, Philadelphia County, PA	08/31/07	WPS Health Insurance	11/26/08	05/04/09	159	9	$169,452	N/A	N/A
22-2045	Kindred Hospital Boston Boston, Suffolk County, MA	08/31/07	WPS Health Insurance	12/05/08	05/04/09	150	12	$367,993	N/A	N/A
39-2028	Kindred Hospital Pittsburgh Oakdale, Allegheny County, PA	08/31/07	WPS Health Insurance	12/23/08	05/04/09	132	9	$100,061	N/A	N/A
22-2044	Kindred Hospital Boston North Shore Peabody, Essex County, MA	08/31/07	WPS Health Insurance	01/06/09	05/04/09	118	6	$203,999	N/A	N/A
39-2032	Kindred Healthcare Delaware Darby, Delaware County, PA	08/31/07	WPS Health Insurance	01/27/09	05/04/09	97	9	$279,040	N/A	N/A
44-5140	Primacy Healthcare & Rehab Memphis, Shelby County, TN	06/30/07	WPS Health Insurance	11/13/08	05/04/09	172	1	$124,356	N/A	N/A

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SCHEDULE OF PRRB PROVIDERS: BAD DEBTS

Group Name Kindred 08 Bad Debts Appeals

Page No. 1 of 1

Representative Glenn P. Hendrix, Arnall Golden Gregory LLP

Date Prepared November 29, 2010

Case No. ~~TBD~~ 10-0090GC

Issue Bad Debt: Must Bill

				A	B	C	D	E	F	G
Provider No.	Provider Name	FYE	Intermediary	Date of Final Determination	Date of Appeal	Number of Days	Audit Adj. No.	Amount of Reimbursement	Original Case No. (if any)	Date of Add/ Transfer
39-2042	Kindred Hospital Wyoming Valley Wilkes Barre, Luzerne County, PA	02/29/08	WPS Health Insurance	08/6/09	11/3/09	89	7	$60,605	N/A	N/A
39-2043	Kindred Hospital Heritage Valley Beaver, Beaver County, PA	06/30/08	WPS Health Insurance	07/24/09	11/3/09	102	4	$23,042	N/A	N/A
44-5140	Primacy Healthcare & Rehab Memphis, Shelby County, TN	06/30/08	WPS Health Insurance	05/13/09	11/3/09	174	7, 9	$120,272	N/A	N/A
22-2044	Kindred Hospital Boston North Shore Peabody, Essex County, MA	08/31/08	WPS Health Insurance	11/24/09	5/10/10	167	11	$169,795	N/A	N/A
22-2045	Kindred Hospital Boston Boston, Suffolk County, MA	08/31/08	WPS Health Insurance	11/20/09	5/10/10	171	9, 13	$247,699	N/A	N/A
39-2027	Kindred Hospital Philadelphia Philadelphia, Philadelphia County, PA	08/31/08	WPS Health Insurance	01/15/10	5/10/10	115	9, 13	$315,471	N/A	N/A
39-2028	Kindred Hospital Pittsburgh Oakdale, Allegheny County, PA	08/31/08	WPS Health Insurance	01/19/10	5/10/10	111	9, 15	$127,467	N/A	N/A
39-2032	Kindred Hospital Delaware Darby, Delaware County, PA	08/31/08	WPS Health Insurance	01/14/10	5/10/10	116	7, 12	$141,512	N/A	N/A
39-2049 39-6110	Kindred Hospital Pittsburgh North Shore Pittsburgh, Allegheny County, PA	9/30/08	WPS Health Insurance	2/25/10	5/10/10	74	16	$75,695	N/A	N/A

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SCHEDULE OF PRRB PROVIDERS: BAD DEBTS

Group Name Kindred 09 Bad Debts Appeals **Page No.** 1 **of** 1

Representative Glenn P. Hendrix, Arnall Golden & Gregory **Date Prepared** 08/18/2015

Case No. 11-0028GC **Issue** Bad Debt: Must Bill

				A	B	C	D	E	F	G
Provider No.	**Provider Name**	**FYE**	**Intermediary**	**Date of Final Determination**	**Date of Appeal**	**Number of Days**	**Audit Adj. No.**	**Amount of Reimbursement**	**Original Case No. (if any)**	**Date of Add/ Transfer**
39-2042	Kindred Hospital Wyoming Valley Wilkes Barre, Luzerne County, PA	02/28/09	WPS Health Insurance	06/28/10	10/11/10	105	10	$24,821	N/A	N/A
39-2043	Kindred Hospital Heritage Valley Beaver, Beaver County, PA	06/30/09	WPS Health Insurance	04/23/10	10/11/10	171	9	$64,794	N/A	N/A
44-5140	Primacy Healthcare & Rehab Memphis, Shelby County, TN	06/30/09	WPS Health Insurance	09/07/10	10/11/10	34	5,6	$43,127	N/A	N/A
22-2044	Kindred Hospital Boston North Shore Peabody, Essex County, MA	08/31/09	WPS Health Insurance	11/05/10	3/15/11	130	6	$149,220	N/A	N/A
22-2045	Kindred Hospital Boston Boston, Suffolk County, MA	08/31/09	WPS Health Insurance	01/18/11	3/15/11	56	11	$208,361	N/A	N/A
39-2027	Kindred Hospital Philadelphia Philadelphia, Philadelphia County, PA	08/31/09	WPS Health Insurance	01/10/11	3/15/11	64	9,14	$358,601	N/A	N/A
39-2028	Kindred Hospital Pittsburgh Oakdale, Allegheny County, PA	08/31/09	WPS Health Insurance	12/17/10	3/15/11	88	8,12	$98,847	N/A	N/A
39-2032	Kindred Hospital Delaware Darby, Delaware County, PA	08/31/09	WPS Health Insurance	12/22/10	3/15/11	83	12	$285,108	N/A	N/A
39-2049	Kindred Hospital Pittsburgh North Shore Pittsburgh, Allegheny County, PA	09/30/09	WPS Health Insurance	12/21/10	3/15/11	84	6,10	$129,369	N/A	N/A

SCHEDULE OF PRRB PROVIDERS: BAD DEBTS

Group Name Kindred 10 Bad Debts Appeals

Page No. 1 of 1

Representative Glenn P. Hendrix, Arnall Golden & Gregory

Date Prepared August 30, 2012

Case No. 12-0147GC

Issue Bad Debt: Must Bill

				A	B	C	D	E	F	G
Provider No.	Provider Name	FYE	Intermediary	Date of Final Determination	Date of Appeal	Number of Days	Audit Adj. No.	Amount of Reimbursement	Original Case No. (if any)	Date of Add/ Transfer
44-5140	Primacy Healthcare & Rehab Memphis, Shelby County, TN	6/30/2010	WPS Health Insurance	7/29/2011	1/23/2012	178	5, 6	$50, 079	N/A	N/A
22-2044	Kindred Hospital Boston North Shore Peabody, Essex County, MA	8/31/2010	WPS Health Insurance	12/2/2011	1/23/2012	52	13	$150, 695	N/A	N/A
22-2045	Kindred Hospital Boston Boston, Suffolk County, MA	8/31/2010	WPS Health Insurance	11/18/2011	1/23/2012	66	6, 10	$315, 918	N/A	N/A
39-2028	Kindred Hospital Pittsburgh Oakdale, Allegheny County, PA	8/31/2010	WPS Health Insurance	11/18/2011	1/23/2012	66	9, 13	$87, 320	N/A	N/A
39-2032	Kindred Hospital Delaware County Darby, Delaware County, PA	8/31/2010	WPS Health Insurance	12/21/2011	1/23/2012	33	7, 11	$233, 066	N/A	N/A
39-2027	Kindred Hospital Philadelphia Philadelphia, Philadelphia County, PA	8/31/2010	WPS Health Insurance	12/22/2011	1/23/2012	32	12	$409, 251	N/A	N/A
39-2049, 39-6110	Kindred Hospital Pittsburgh North Shore Pittsburgh, Alleghany County, PA	9/30/2010	WPS Health Insurance	12/21/2011	1/23/2012	33	8, 14	$74, 695	N/A	N/A
39-2043	Kindred Hospital Heritage Valley Beaver, Beaver County MA	6/30/2010	WPS Health Insurance	10/21/2011	4/17/2012	179	8	$160,363	N/A	N/A

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SCHEDULE OF PRRB PROVIDERS: BAD DEBTS

Page No. 1 of 1

Group Name Kindred Healthcare 2011 Bad Debts CIRP Group

Representative Glenn P. Hendrix, Arnall Golden & Gregory

Date Prepared March 28, 2014

Case No. 13-2822GC

Issue Bad Debt: Must Bill

Lead Intermediary WPS Health Insurance

				A	B	C	D	E	F	G
Provider No.	Provider Name / Location	FYE	Intermediary / MAC	Date of Final Determination	Date of Hearing Request / Add Issue Request	No. of Days	Audit Adj. No.	Amount in Controversy	Prior Case No(s).	Date of Direct Add/ Transfer(s) to Group
22-2044	Kindred Hospital Boston North Shore Peabody, Essex County, MA	8/31/2011	WPS Health Insurance	5/1/2013	08/13/2013	104	8, 12	$201,701	N/A	N/A
22-2045	Kindred Hospital Boston Boston, Suffolk County, MA	8/31/2011	WPS Health Insurance	4/15/2013	08/13/2013	120	7, 12	$180,889	N/A	N/A
39-2027	Kindred Hospital Philadelphia Philadelphia, Philadelphia County, PA	8/31/2011	WPS Health Insurance	2/18/2013	08/13/2013	117	9, 15	$590,684	N/A	N/A
39-2028	Kindred Hospital Pittsburgh Oakdale, Allegheny County, PA	8/31/2011	WPS Health Insurance	4/12/2013	08/13/2013	123	8, 14	$144,220	N/A	N/A
39-2032	Kindred Hospital Delaware County Darby, Delaware County, PA	8/31/2011	WPS Health Insurance	4/5/2013	08/13/2013	130	8, 11	$278,502	N/A	N/A
39-2049	Kindred Hospital Pittsburgh North Shore Pittsburgh, Alleghany County, PA	9/30/2011	WPS Health Insurance	5/16/2013	08/13/2013	89	18	$84,357	N/A	N/A

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SCHEDULE OF PRRB PROVIDERS: BAD DEBTS

Group Name Kindred 12 Bad Debts Appeals

Representative Glenn P. Hendrix, Arnall Golden & Gregory

Case No. 14-1622GC

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Date Prepared 8/18/2015

Issue Bad Debt: Must Bill

				A	B	C	D	E	F	G
Provider No.	Provider Name	FYE	Intermediary	Date of Final Determination	Date of Appeal	Number of Days	Audit Adj. No.	Amount of Reimbursement	Original Case No. (if any)	Date of Add/ Transfer
22-2045	Kindred Hospital Boston Boston, Suffolk County, MA	08/31/12	WPS Health Insurance	11/18/13	01/03/14	46	8	$230,415	N/A	N/A
39-2028	Kindred Hospital Pittsburgh Oakdale, Allegheny County, PA	08/31/12	WPS Health Insurance	11/25/13	01/03/14	39	13	$114,656	N/A	N/A
39-2042	Kindred Hospital Wyoming Valley Wilkes Barre, Luzerne County, PA	02/28/12	WPS Health Insurance	07/05/13	01/03/14	182	6,9	$160,551	N/A	N/A
39-2043	Kindred Hospital Heritage Valley Beaver, Beaver County, PA	06/30/12	WPS Health Insurance	11/27/13	01/03/14	37	5	$66,566	N/A	N/A
39-2027	Kindred Hospital Philadelphia Philadelphia, Philadelphia County, PA	08/31/12	WPS Health Insurance	01/17/14	03/12/14	54	15	$440,262	N/A	N/A
22-2044	Kindred Hospital Boston North Shore Peabody, Essex County, MA	08/31/12	WPS Health Insurance	01/31/14	03/24/14	52	10	$166,374	N/A	N/A
39-2049	Kindred Hospital Pittsburgh North Shore Pittsburgh, Allegheny County, PA	09/30/12	WPS Health Insurance	03/14/14	04/14/14	31	10	$86,111	N/A	N/A
39-2046	Kindred Hospital South Philadelphia Philadelphia, Philadelphia County, PA	10/31/12	Novitas Solutions	09/11/14	09/24/14	13	16	$255,266	N/A	N/A
39-2032	Kindred Hospital Delaware County Darby, Delaware County, PA	10/31/12	Wisconsin Physicians Service	06/24/15	07/28/15	34	4	$202,208	N/A	N/A

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MODEL FORM G: SCHEDULE OF PROVIDERS IN GROUP

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Case No.: 15-3239GC

Date Prepared September 4, 2015

Group Name Kindred Healthcare 2013 Bad Debts CIRP Group

Group Representative Glenn P. Hendrix, Arnall Golden & Gregory

Lead Intermediary WPS Health Insurance

					A	B	C	D	E	F	G
#	Provider No.	Provider Name / Location	FYE	Intermediary / MAC	Date of Final Determination	Date of Hearing Request / Add Issue Request	No. of Days	Audit Adj. No.	Amount in Controversy	Prior Case No(s).	Date of Direct Add/ Transfer(s) to Group
1	22-2044	Kindred Hospital Boston North Shore Peabody, Essex County, MA	8/31/2013	WPS Health Insurance	5/21/2015	08/18/2015	89	8	$143,341	N/A	N/A
2	22-2045	Kindred Hospital Boston Boston, Suffolk County, MA	8/31/2013	WPS Health Insurance	7/20/2015	08/18/2015	29	12	$252,746	N/A	N/A

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MODEL FORM G: SCHEDULE OF PROVIDERS IN GROUP

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Case No.: 16-1252GC

Date Prepared May 25, 2017

Group Name Kindred Healthcare 2014 Bad Debts CIRP Group

Group Representative Glenn P. Hendrix, Arnall Golden & Gregory

Lead Intermediary WPS Health Insurance

					A	B	C	D	E	F	G
#	Provider No.	Provider Name / Location	FYE	Intermediary / MAC	Date of Final Determination	Date of Hearing Request / Add Issue Request	No. of Days	Audit Adj. No.	Amount in Controversy	Prior Case No(s).	Date of Direct Add/ Transfer(s) to Group
1	22-2044	Kindred Hospital Boston North Shore Peabody, Essex County, MA	8/31/2014	WPS Health Insurance	11/24/2015	03/04/2016	111	12	$150,398	N/A	N/A
2	22-2045	Kindred Hospital Boston Boston, Suffolk County, MA	8/31/2014	WPS Health Insurance	11/11/2015	03/04/2016	124	12	$230,800	N/A	N/A

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