PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2019-D34

PROVIDER –
HMA 2004-2006 Bad Debt Group Appeals

PROVIDER NOS. –
Appendix I

vs.

MEDICARE CONTRACTOR –
Wisconsin Physicians Service/
Federal Specialized Services, Inc.

DATE OF HEARING – July 15, 2019

Cost Reporting Periods Ended–
FYEs 2004, 2005 and 2006

CASE NOS.: 07-2227GC; 07-2762GC; and 08-1704GC

INDEX

ISSUE STATEMENT:

Whether the Providers engaged in "reasonable collection efforts," notwithstanding their differential treatment of Medicare and non-Medicare bad debts, in light of the Board's decisions in *Reed City Hosp. v. BlueCross BlueShield Ass'n* ("*Reed City*")[1] and *St. Francis Hosp. & Med. Ctr. v. BlueCross BlueShield Ass'n* ("*St. Francis*").[2]

DECISION:

After considering Medicare law and regulations, arguments presented, the evidence admitted, and, as directed on remand, applying the more flexible pre-moratorium approach used in the Board's decision in *Reed City* and *St. Francis*, the Provider Reimbursement Review Board ("Board") finds that the Health Management Associates Providers ("HMA Providers") did not engage in "reasonable collection efforts," as they did not supply evidence to support their belief that the secondary collection agencies' recovery rates for Medicare accounts, would be less than those for similar-value non-Medicare accounts. Accordingly, the Board affirms the Medicare Contractor's adjustments.

INTRODUCTION:

The HMA Providers in these three group appeals are all short-term acute care hospitals, located in multiple states.[3] The group appeals concern bad debts claimed in fiscal years ("FYs") 2004, 2005, and 2006. The Medicare contractor[4] assigned to the HMA Providers is Wisconsin Physicians Service, f/k/a Mutual of Omaha Insurance Company (the "Medicare Contractor"). The Medicare Contractor removed the bad debts at issue because the HMA Providers used a secondary collection agency for their non-Medicare accounts but did not use one for their Medicare accounts. The Board issued a decision[5] in these three group appeals finding that the HMA Providers failed to meet the "reasonable collection effort" standard of the Provider Reimbursement Manual, CMS Pub. 15-1 ("PRM 15-1"), § 310.

The HMA Providers subsequently sought judicial review of the Board's decision, and the appeal is now back before the Board on remand from the U.S. District Court for the District of Columbia ("District Court").[6] The District Court remanded these group appeals to the Board because, based on the appellate record, the court could not "assess whether Plaintiffs' judgment was reasonable in light of the facts of this case and, accordingly, whether an 'occasional exception' to the Section 310 standard is warranted here."[7]

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[1] PRRB Dec. No. 86-D67 (Feb. 20, 1986), *decl'd review*, Adm'r (Mar. 31, 1986).
[2] PRRB Dec. No. 86-D21 (Nov. 12, 1985).
[3] *See* Appendix I for Summary of the HMA Providers by CIRP.
[4] CMS' payment and audit functions under the Medicare program were historically contracted to organizations known as fiscal intermediaries ("FIs") and these functions are now contracted with organizations know as Medicare administrative contractors ("MACs"). The term "Medicare Contractor" refers to both FIs and MACs as appropriate.
[5] *HMA 2004-2006 Bad Debt Group Appeals v. Wisconsin Phys. Serv.*, PRRB Dec. No. 2014-D30 (Sept. 25, 2014), *decl'd review*, Adm'r (Oct. 28, 2014).
[6] *Winder HMA LLC v. Burwell*, 206 F. Supp. 3d 22 (D.D.C. 2016).
[7] *Id.* at 45.

The Board held a hearing on the record. The HMA Providers were represented by Joanne Erde, Esq., Duane Morris LLP. The Medicare Contractor was represented by Bernard M. Talbert, Esq., Federal Specialized Services.

STATEMENT OF FACTS AND RELEVANT LAW:

Medicare bad debts are unpaid costs attributable to the deductible and coinsurance amounts of Medicare beneficiaries.[8] Bad debts are reimbursable under the Medicare Program if they meet the following criteria:

> (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.[9]

As previously indicated, PRM 15-1 § 310 further interprets the concept of "reasonable collection efforts" in (2) above as follows:

> To be considered a reasonable collection effort, a provider's effort to collect Medicare deductible and coinsurance amounts must be similar to the effort the provider puts forth to collect comparable amounts from non-Medicare patients. It must involve the issuance of a bill on or shortly after discharge or death of the beneficiary to the party responsible for the patient's personal financial obligations. It also includes other actions such as subsequent billings, collection letters and telephone calls or personal contacts with this party which constitute a genuine, rather than a token, collection effort. The provider's collection effort may include using or threatening to use court action to obtain payment. (See § 312 for indigent or medically indigent patients.)
>
> A. Collection Agencies. —A provider's collection effort may include the use of a collection agency in addition to or in lieu of subsequent billings, follow-up letters, telephone and personal contacts. Where a collection agency is used, Medicare expects the provider to refer all uncollected patient charges of like amount to the agency without regard to class of patient. The "like amount" requirement may include uncollected charges above a specified minimum amount. Therefore, if a provider refers to a collection agency its uncollected non-Medicare patient charges which in amount are comparable to the individual Medicare deductible and

[8] 42 C.F.R. § 413.89(d).
[9] *See* 42 C.F.R. § 413.89(e).

> coinsurance amounts due the provider from its Medicare patient, Medicare requires the provider to also refer its uncollected Medicare deductible and coinsurance amounts to the collection agency. Where a collection agency is used, the agency's practices may include using or threatening to use court action to obtain payment.
>
> B. Documentation Required. —The provider's collection effort should be documented in the patient's file by copies of the bill(s), follow-up letters, reports of telephone and personal contact, etc.

PRM 15-1 § 310.2 sets forth a "presumption of noncollectibility." Specifically, § 310.2 states that: "If after reasonable and customary attempts to collect a bill, the debt remains unpaid more than 120 days from the date the first bill is mailed to the beneficiary, the debt may be deemed uncollectible."

Congress enacted several statutory provisions during the time period of 1987 through 1989 which essentially "froze" Medicare bad debt reimbursement policy as it was prior to August 1, 1987.[10] These provisions, known as the "Bad Debt Moratorium" ceased to apply to cost reporting periods beginning on or after October 1, 2012.[11] However, until that time (including the time period at issue in this case), the Bad Debt Moratorium prohibited the Secretary of the Department of Health and Human Services ("Secretary") from making any changes to bad debt policy which was in effect on August 1, 1987. Specifically, the Bad Debt Moratorium states:

> [W]ith respect to payment under [the Medicare program] to providers of service for reasonable costs relating to unrecovered costs associated with unpaid deductible and coinsurance amounts incurred under such title (including criteria for what constitutes a reasonable collection effort, including criteria . . . for determining whether to refer a claim to an external collection agency). The Secretary may not require a hospital to change its debt collection policy if a fiscal intermediary, in accordance with the rules in effect as of August 1, 1987, with respect to criteria for . . . determining whether to refer a claim to an external collection agency, has accepted such policy before that date, and the Secretary may not collect from the hospital on the basis of an expectation of a change in the hospital's collection policy.[12]

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[10] In § 4008(c) of the Omnibus Budget Reconciliation Act of 1987, Congress enacted a noncodified statutory provision that became known as the ""Bad Debt Moratorium." *See* Pub. L. No. 100-203, 101 Stat. 1330, 1330-55 (1987). In 1988, in § 8402 of the Technical and Miscellaneous Revenue Act of 1988, Congress retroactively amended the Bad Debt Moratorium. *See* Pub. L. No. 100-647, 102 Stat. 3342, 3798 (1988). In 1989, in § 6023 of the Omnibus Budget Reconciliation Act of 1989, Congress again retroactively amended the Bad Debt Moratorium. *See* Pub. L. No. 101-239, 103 Stat. 2106, 2167 (1989). These changes collectively are referred to as the "Bad Debt Moratorium" and the full text of this non-codified statutory provision as amended is reprinted at 42 U.S.C. § 1395f note entitled "Continuation of Bad Debt Recognition for Hospital Services."

[11] Middle Class Tax Relief Job Creation Act of 2012, Pub. L. No. 112–96, § 3201(d), 126 Stat. 156, 192-93 (2012).

[12] 42 U.S.C. § 1395f note entitled "Continuation of Bad Debt Recognition for Hospital Services."

In its initial decision in this case,[13] the Board concluded that the Medicare Contractor properly removed certain non-indigent Medicare bad debts from the HMA Providers' cost reports. Its decision was based upon PRM 15-1 § 310, which requires that in order "[t]o be considered a reasonable collection effort, a provider's effort to collect Medicare deductible and coinsurance amounts must be similar to the effort the provider puts forth to collect comparable amounts from non-Medicare patients."[14]

Specifically, the Board found that the HMA Providers' use of a secondary collection agency for non-Medicare patient accounts, but not for Medicare patient accounts, violated the similar effort requirement of the PRM.[15] The Board reasoned that the SCA was a part of the HMA Providers' customary collection process, and the presumption of noncollectibility of Medicare accounts under PRM 15-1 § 310.2 was not applicable because the Medicare collection efforts were not similar to its non-Medicare collection efforts, and the rationale for this different treatment of accounts was not reasonable.[16] The Board further found the Medicare Contractor did not violate the Bad Debt Moratorium because there was nothing in the record showing that the Medicare Contractor approved the HMA Providers' policy of only sending non-Medicare bad debts to a secondary collection agency.[17]

The HMA Providers subsequently filed suit in the District Court and the District Court concluded that the Secretary's rigid application of § 310 "violates the Bad Debt Moratorium's prohibition on alterations to the Secretary's bad-debt polices after August 1, 1987."[18] Specifically, the District Court vacated the Board's decision, providing the following instructions:

> On remand, the Board should determine whether the Hospitals' belief that the recovery rates for Medicare accounts would be less than those for similar-value non-Medicare accounts sent to [secondary collection agencies] was supported by evidence beyond mere assumptions about Medicare patients as a group. *St. Francis* and *Reed City*, moreover, should assist in framing the issues. In *Reed City*, for instance, the provider represented to the Board that it "did not submit the Medicare uncollectibles to the collection agency because its recovery rate would have been negligible due to the highly indigent population of its service area. Further, since the Intermediary audit, the provider [began] forwarding its delinquent Medicare patient accounts to the collection agency with virtually insignificant results." *Reed City* at 2. The Board found that in light of this, and because the provider's in-house collection efforts were "acceptable and appropriate," the Medicare bad debts were

[13] PRRB Dec. No. 2014-D30.
[14] *Id.* at 3.
[15] *Id.* at 9.
[16] *Id.*at 9-10.
[17] *Id* at 21.
[18] *Winder HMA LLC v. Burwell*, 206 F. Supp. 3d at 42.

> reimbursable notwithstanding the provider's differential treatment of the two kinds of accounts. *Id*. at 3-4. In *St. Francis*, similarly, the provider referred its Medicare and non-Medicare accounts to a collection agency after its in-house collection efforts, but had little success with the Medicare accounts. *See St. Francis* at 1 (noting that "no amounts were recovered from the Medicare beneficiaries for the 1983 fiscal year"). The Board found that this experiment was sufficient to "demonstrate[ ] that writing off bad debts when their pursuit would be too costly was a reasonable practice," and because "the provider's in-house collection efforts constituted a reasonable collection effort," the Medicare bad debts could be reimbursed. *Id*. at 1- 2.
>
> In both cases, therefore, the Board found that an exception to the similar-collection efforts standard in Section 310 was appropriate where the provider had demonstrated that its primary collection efforts were adequate and similar among all kinds of accounts, and that using a collection agency for Medicare accounts after such efforts would yield little or no additional recovery. Of course, these are not the only cases that establish the circumstances under which sound business judgment might reasonably counsel against employing identical collection efforts for Medicare and non-Medicare accounts; other PRRB decisions before August 1, 1987, may offer additional guidance for the Board on remand.[19]

The District Court further directed:

> Should the Board ultimately find insufficient evidence to support the Hospitals' claim that their decision to send only non-Medicare accounts to a secondary collection agency was supported by "sound business judgment," it may again affirm the Intermediary's disallowances. On the other hand, if Plaintiffs can demonstrate, on remand, that their decision was reasonable and supported by their experience with Medicare bad-debt collection, the similar-collection-efforts standard should not bar reimbursement."[20]

Based on the District Court's actions, the following three Board decisions are relevant to this case.

A. The Board's decision in *Reed City*

In *Reed City*, the provider's collection policy included:

1) obtaining deposits from patients;

[19] *Id.* at 45-46.
[20] *Id.* at 46.

2) attempting to collect all deductibles at the time of admission;
3) evaluating patients' capability to pay;
4) determining Hill-Burton eligibility;
5) establishing procedures to collect billings within 90 days; and
6) sending unpaid accounts to a small claims court or a collection agency if not paid within 90 days.[21]

Following its in-house collection efforts, the provider sent only non-Medicare bad debts to the collection agency. The Medicare Contractor in that case denied reimbursement of Medicare bad debts based upon the "reasonable collection effort" requirement of PRM 15-1 § 310.

The record in *Reed City* includes documentation that the provider based its decision not to send Medicare bad debts to a collection agency because its recovery rate would have been negligible *due to the highly indigent population* ***of its service area*** and that, after the audit at issue, it began forwarding its delinquent Medicare patient accounts to the collection agency with virtually insignificant results.[22]

Based on facts and uncontroverted evidence submitted in the *Reed City* case, the Board concluded that the provider's collection policies reflected that it maintained reasonable collection efforts on Medicare accounts deemed uncollectible . . .",[23] and the Board concluded that "[t]he [p]rovider's collection efforts are reasonable . . ."[24]

B. <u>The Board's decision in *St. Francis*</u>

In *St. Francis*, the provider's collection efforts for all accounts involved sending out a bill three (3) days after a patient was discharged, and every thirty (30) days thereafter for six (6) months. Thereafter, the Medicare accounts were written off and the non-Medicare accounts were turned over to a collection agency. The record shows St. Francis referred its FYE 1983 and 1984 Medicare accounts to a collection agency, but no amounts were recovered from Medicare beneficiaries for the 1983 fiscal year. The provider contended that these poor collection results justified its action for not referring FYEs 1980, 1981, and 1982 to a collection agency.

The Board found in *St. Francis* that substantial evidence demonstrated the provider's collection efforts for Medicare bad debts met the "reasonable collection efforts" requirement. The Board noted it was reasonable to write off bad debts when their pursuit would be too costly, and it accepted the zero recovery results of the collection agency for 1983 as proof that there was negligible likelihood of recovery for the FYs 1980, 1981 and 1982 Medicare bad debts.[25]

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[21] PRRB Dec. No. 86-D67 at 2.
[22] *Id.*
[23] *Id.* at 4.
[24] *Id.*
[25] PRRB Dec. No. 86-D21 at 7.

C. The Board's decision in *Mountain States*

Between the time of the District Court remand and the present, the Board issued a decision based on the remand from the District Court in a similar bad debt case, *Mountain States Health Alliance 05 Bad Debt – Passive Collection CIRP Group ("Mountain States").*[26] As in the HMA cases at issue here, the *Mountain States* providers had originally been denied bad debt reimbursement "on the ground that the [p]roviders did not use similar efforts to collect Medicare and non-Medicare bad debt and, in particular, continued to employ collection agencies to pursue certain non-Medicare debt, but not Medicare debt." [27] The District Court in *Mountain States* remanded the case back to the Board with instructions that the Board "should apply the more flexible pre-Moratorium approach reflected in *Reed City* and *St. Francis* in order to determine whether the [p]roviders engaged in 'reasonable collection efforts' notwithstanding their differential treatment of Medicare and non-Medicare bad debt."[28]

On remand, the Board found that the *Mountain States* providers had not engaged in reasonable collection efforts of their Medicare bad debt, even applying the more flexible *Reed City* and *St. Francis* approaches because, among other reasons:

(1) The record showed that the *Mountain States* providers had, in fact, collected not insubstantial amounts related to Medicare accounts from the secondary collection agency;

(2) The providers had failed to prove that its secondary collection costs exceeded the amount collected on Medicare debt or that it was too costly to refer any Medicare accounts; and

(3) A provider witness testified that the collection rate on a Medicare account as compared to a non-Medicare account is the same if not more.[29]

The Board concluded that "even when applying the more flexible pre-moratorium approach the Mountain States [p]roviders' debt collection procedure is not like that of the providers in *Reed City* or *St. Francis* as they did not engaged [sic] in reasonable collection efforts because their decision not to refer an account to the secondary collection agency was made based upon class of patient not on the likelihood that the account would be collected."[30]

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[26] *Mountain States Health Alliance v. Burwell,* 128 F. Supp. 3d 195 (D.D.C. 2015), *vacating*, *Mountain States Health Alliance 05 Bad Debt-Passive Collection CIRP Group v. BlueCross BlueShield Ass'n*, PRRB Dec. No. 2013-D6 (Mar. 4, 2013) (the Board's decision was the final agency determination as the Administrator declined review on April 24, 2013).
[27] *Id.* at 197.
[28] *Id.* at 222.
[29] *Mountain States Health Alliance 05 Bad Debt – Passive Collection CIRP Group v. Cahaba Gov. Benefits*, PRRB Dec. No. 2018-D18 at 7 (Jan. 26, 2018), *decl'd review*, Adm'r (Mar. 27, 2018).
[30] *Id.* at 8.

DISCUSSION, FINDINGS OF FACT AND CONCLUSIONS OF LAW:

The HMA Providers in these three group appeals claim they have engaged in "reasonable collection efforts" under the standards evidenced in the *Reed City* and *St. Francis* cases. The HMA Providers explain that after in-house and primary collection agency efforts for all accounts, they "wrote these accounts off" because they determined using sound business judgment "that *both* the Medicare and non-Medicare accounts were uncollectible and there was no likelihood of collection in the future."[31] The HMA Providers then sent *only* non-Medicare bad debt to secondary collection agencies.[32]

The HMA Providers argue that their collection efforts exceeded the standard for reasonable collection efforts established in *Reed City* and *St. Francis* because their *in-house* collection efforts worked the accounts for approximately 55-60 days, sending a series of four (4) or five (5) letters to patients and numerous phone calls. Once *in-house* collection efforts were completed, all unpaid accounts were sent to an outside "primary" collection agency. The outside primary collection agency would continue pursuing the account with letters, phone calls, and credit bureau reporting. The accounts were also reviewed for legal action.[33] The outside primary collection agency would determine the accounts were uncollectible somewhere after approximately 150 to 180 days of collection efforts. There was no differentiation between Medicare and non-Medicare patient accounts during this period. Accounts deemed uncollectible by the outside primary collection agency were returned to the HMA Providers as uncollectible. These accounts were generally 260 days old at the time of return. These returned, uncollectible accounts included both Medicare accounts and non-Medicare accounts.[34]

The HMA Providers contend that their collection efforts greatly exceed the collection efforts established in *Reed City* and *St. Francis* explaining that their in-house and outside primary collection efforts lasted six (6) months or longer on all accounts. In contrast, the collection efforts on Medicare accounts in the *Reed* City case lasted only 90 days, while collection efforts on Medicare accounts in the *St. Francis* case lasted no more than six (6) months.[35]

Finally, the HMA Providers argue they used sound business judgment when they determined that all accounts were uncollectible after the in-house and outside primary collection efforts were finished. The HMA Providers explain their efforts included:

(1) The repeated review of the accounts for bankruptcy or death;
(2) Repeated verification of addresses and phone numbers;
(3) The issuance of numerous collection letters demanding payment;
(4) Frequent phone calls at all times of the day and in the evening;
(5) Recording debts on debtors' credit reports; and
(6) Making a determination that legal action was not appropriate.[36]

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[31] Providers' Brief on Remand from the District Court, 16 (June 20, 2017).
[32] Administrative Record ("AR"), 179.
[33] Providers' Brief on Remand from the District Court at 12-15
[34] *Id.* at 16.
[35] *Id.* at 17-18.
[36] *Id.* at 21.

The HMA Providers also state the decision to write-off these accounts was made because HMA is a publicly-traded company, and revenue and bad debts are a benchmark used to measure public companies.[37]

The Board finds the HMA Providers did not engage in "reasonable collection efforts." In reviewing these cases, the Board identifies several distinguishing factors between the HMA Providers and the aforementioned *Reed City* and *St. Francis* cases. The Board in *Reed City* and *St. Francis* accepted the "insignificant" and "zero" collections realized in subsequent years as proof that use of a collection agency was ineffective and too costly for Medicare accounts. By contrast, the HMA Providers did not supply any evidence regarding actual or potential recovery rates for Medicare accounts at secondary collection agencies. Rather, they simply did not refer Medicare accounts to secondary collection agencies at all.[38] Further, it is clear that the HMA Providers collected not insignificant or negligible revenue on the *non*-Medicare accounts sent to the secondary collection agencies as that revenue collection was in the range of 3.5 to 6.5 percent.[39] As explained below, without evidence to the contrary, the Board is unable to conclude that there would have been different potential recovery rate for the Medicare and non-Medicare accounts.

The HMA Providers claim the decision not to send Medicare accounts to a secondary collection agency was based on sound business judgment. The Board disagrees and finds that it was not based on sound business judgement. Rather, the Board finds this claim is based on unsupported broad and general assertions that Medicare collections would be less than the non-Medicare collections (such as testimony that Medicare patients are less likely to have a "life event" which would result in account payment, due to their age).[40] Absent actual evidence to support their assertions, the Board is unable to conclude that the recovery rate on Medicare accounts at secondary collection agencies would likely have been less than the collection rate on non-Medicare accounts at those same agencies.[41] In fact, based on the evidence presented, the only conclusion the Board can reach is that the decision to not refer the Medicare accounts to secondary collection agencies was based on class of patient and not sound business judgment.

In conclusion, the Board finds that even when applying the more flexible pre-moratorium approach used in *Reed City* and *St. Francis,* the HMA Providers' collection efforts regarding Medicare accounts was not reasonable, nor based upon sound business judgment. Unlike the providers in *Reed City* or *St. Francis,* the HMA Providers have not established that the use of secondary collection agencies was ineffective or too costly for Medicare accounts. On the contrary, the HMA Providers continued to recover non-Medicare accounts with the use of

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[37] *Id.* at 22.
[38] AR at 182 and 316.
[39] *Id.* at 318.
[40] *Id.* at 254.
[41] The fact that the HMA Providers' collection efforts on Medicare accounts prior to their being written off may have been potentially greater than those of the providers in *Reed City* and *St. Francis* is not relevant. Rather, as shown in *Reed City* and *St. Francis,* what is relevant are such factors as the costliness of continued pursuit and the likelihood of recovery based on that continued pursuit because they address whether the HMA Providers' divergence in treatment of Medicare and non-Medicare accounts is reasonable and based on sound business judgement.

secondary collection agencies, and have failed to establish that sound business judgment dictated the decision to not refer Medicare accounts for secondary collection efforts. The Board affirms the Medicare Contractors' disallowances of these bad debts.

DECISION AND ORDER:

After considering Medicare law and regulations, arguments presented, the evidence admitted, and, as directed on remand, applying the approach used in the Board's decision in *Reed City*[42] and *St. Francis,*[43] the Board finds the HMA Providers did not engage in "reasonable collection efforts" as they did not supply evidence to support their belief that the secondary collection agencies' recovery rates for Medicare accounts, would be less than those for similar-value non-Medicare accounts. Accordingly, the Board affirms the Medicare Contractor's adjustments.

BOARD MEMBERS PARTICIPATING:

Clayton J. Nix, Esq.
Charlotte F. Benson, C.P.A.
Gregory H. Ziegler, C.P.A., CPC-A
Robert A. Evarts, Esq.
Susan A. Turner, Esq.

FOR THE BOARD:

7/26/2019

X Clayton J. Nix

Clayton J. Nix, Esq.
Chair
Signed by: Clayton J. Nix -A

[42] *Reed City Hosp. v. BlueCross BlueShield Ass'n*, PRRB Dec. No. 86-D67 (Feb. 20, 1986).
[43] *St. Francis Hosp. & Med. Ctr. v. BlueCross BlueShield Ass'n*, PRRB Dec. No. 86-D21 (Nov. 12, 1985).

Appendix I

SUMMARY OF THE PROVIDERS BY CIRP

MODEL FORM G: REVISED SCHEDULE OF PROVIDERS IN GROUP

Group Name: HMA 2004 Bad Debt Group Appeal **Page 1 of 2**

Representative: Joanne B. Erde, Esq., Duane Morris LLP **Date Prepared: 05/27/09**

Case Number (if known): 07-2227G

Issue: Whether the Intermediary erred in disallowing the Providers' Part A and Part B bad debts for services rendered to Medicare Beneficiaries.

	Provider Number	Provider Name/Location (city, county, state)	FYE	Intermediary	A Date of Final Determination	B Date of Appeal	C No. of Days	D Audit Adj. No.	E Amount of Reimbursement	F Original Case No.	G Date(s) of Add/ Transfer
1.	42-0010	Carolina Pines Regional Medical Center Hartsville, Darlington County, South Carolina	09/30/04	Mutual of Omaha Insurance Company	10/13/06	04/03/07	172	9, 12	$419,000	07-1683	06/27/07
2.	34-0129	Lake Norman Regional Medical Center Mooresville, Iredell County, North Carolina	09/30/04	Mutual of Omaha Insurance Company	09/22/06	03/13/07	172	15, 22	$585,000	07-1125	06/27/07
3.	39-0061	Lancaster Regional Medical Center Lancaster, Lancaster County, Pennsylvania	06/30/04	Mutual of Omaha Insurance Company	09/20/06	03/13/07	174	32	$227,000	07-1133	06/27/07

MODEL FORM G: REVISED SCHEDULE OF PROVIDERS IN GROUP

Group Name: HMA 2004 Bad Debt Group Appeal **Page 2 of 2**

Representative: Joanne B. Erde, Esq., Duane Morris LLP **Date Prepared: May 28, 2009**

Case Number (if known): 07-2227G

Issue: Whether the Intermediary erred in disallowing the Providers' Part A and Part B bad debts for services rendered to Medicare Beneficiaries.

	Provider Number	Provider Name/Location (city, county, state)	FYE	Intermediary	A Date of Final Determination	B Date of Appeal	C No. of Days	D Audit Adj. No.	E Amount of Reimbursement	F Original Case No.	G Date(s) of Add/ Transfer
4.	18-0078	Paul B. Hall Regional Memorial Center Paintsville, Johnson County, Kentucky	09/30/04	Mutual of Omaha Insurance Company	09/01/06	02/26/07	178	12, 15	$182,000	07-0935	06/27/07
5.	25-0096	Rankin Medical Center Brandon, Rankin County, Mississippi	12/31/04	Mutual of Omaha Insurance Company	09/22/06	03/12/07	171	30	$105,000	07-1126	06/26/07 12/13/07
6.	51-0077	Williamson Memorial Hospital Williamson, Mingo County, West Virginia	09/30/04	Mutual of Omaha Insurance Company	08/23/06	02/16/07	176	15, 18	$270,000	07-0869	05/30/07 06/27/07

MODEL FORM G: REVISED SCHEDULE OF PROVIDERS IN GROUP VOL. 1 OF 2

Group Name: HMA 2005 Bad Debt Group Appeal Page 1 of 9

Representative: Joanne B. Erde, Esq., Duane Morris LLP Date Prepared: 05/27/09

Case Number (if known): 07-2762G Issue: **Whether the Intermediary erred in disallowing the Providers' Part A and Part B bad debts for services rendered to Medicare Beneficiaries.**

	Provider Number	Provider Name/Location (city, county, state)	FYE	Intermediary	A Date of Final Determination	B Date of Appeal	C No. of Days	D Audit Adj. No.	E Amount of Reimbursement	F Original Case No.	G Date(s) of Add/ Transfer
1.	25-0007	Biloxi Regional Medical Center Biloxi, Harrison County, Mississippi	09/30/05	Mutual of Omaha Insurance Company	01/26/07	07/13/07	168	8	295,000	07-2390	09/11/07
2.	42-0010	Carolina Pines Regional Medical Center Hartsville, Darlington County, South Carolina	09/30/05	Mutual of Omaha Insurance Company	02/12/07	07/27/07	165	17, 22	515,000	07-2477	09/11/07
3.	LEFT BLANK INTENTIONALLY										
4.	10-0047	Charlotte Regional Medical Center Punta Gorda, Charlotte County, Florida	09/30/05	Mutual of Omaha Insurance Company	06/13/07	12/07/07	177	21, 24, 25, 33	381,000	08-0375	02/19/08
5.	34-0144	Davis Regional Medical Center Statesville, Iredell	09/30/05	Mutual of Omaha Insurance	03/12/07	08/13/07	154	33, 37, 38	280,000	07-2644	09/11/07 09/20/07

MODEL FORM G: SCHEDULE OF PROVIDERS IN GROUP

Group Name: HMA 2005 Bad Debt Group Appeal **Page 2 of 9**

Representative: Joanne B. Erde, Esq., Duane Morris LLP **Date Prepared:**

Case Number (if known): 07-2762G **Issue: Whether the Intermediary erred in disallowing the Providers' Part A and Part B bad debts for services rendered to Medicare Beneficiaries.**

	Provider Number	Provider Name/Location (city, county, state)	FYE	Intermediary	A Date of Final Determination	B Date of Appeal	C No. of Days	D Audit Adj. No.	E Amount of Reimbursement	F Original Case No.	G Date(s) of Add/ Transfer
		County, North Carolina		Company							
6.	11-0075	East Georgia Regional Medical Center Statesboro, Bulloch County, Georgia	09/30/05	Mutual of Omaha Insurance Company	02/07/07	07/27/07	170	19, 21	381,000	07-2479	09/11/07
7.	34-0036	Franklin Regional Medical Center Louisberg, Franklin County, North Carolina	09/30/05	Mutual of Omaha Insurance Company	06/15/07	12/06/07	174	10, 14	261,000	08-0373	02/19/08
8.	34-0106	Hamlet Hospital Hamlet, Richmond County, North Carolina	09/30/05	Mutual of Omaha Insurance Company	08/24/07	02/15/08	175	11, 12, 15, 20, 23	601,000	08-1272	04/23/08

MODEL FORM G: SCHEDULE OF PROVIDERS IN GROUP

Group Name: HMA 2005 Bad Debt Group Appeal **Page 3 of 9**

Representative: Joanne B. Erde, Esq., Duane Morris LLP **Date Prepared:**

Case Number (if known): 07-2762G **Issue: Whether the Intermediary erred in disallowing the Providers' Part A and Part B bad debts for services rendered to Medicare Beneficiaries.**

	Provider Number	Provider Name/Location (city, county, state)	FYE	Intermediary	A Date of Final Determination	B Date of Appeal	C No. of Days	D Audit Adj. No.	E Amount of Reimbursement	F Original Case No.	G Date(s) of Add/ Transfer
9.	44-0144	Harton Regional Medical Center Tullahoma, Coffee County, Tennesse	05/31/05	Mutual of Omaha Insurance Company	09/21/07	03/06/08	167	34	198,000	08-1416	04/23/08
10.	10-0137	Heart of Florida Regional Medical Center Davenport, Polk County, Florida	06/30/05	Mutual of Omaha Insurance Company	09/11/07	02/26/08	168	23, 29	367,000	08-1222	03/31/08
11.	10-0049	Highlands Regional Medical Center Sebring, Highlands County, Florida	09/30/05	Mutual of Omaha Insurance Company	06/15/07	12/07/07	175	12, 17,	197,000	08-0372	02/19/08

MODEL FORM G: SCHEDULE OF PROVIDERS IN GROUP

Group Name: HMA 2005 Bad Debt Group Appeal **Page 4 of 9**

Representative: Joanne B. Erde, Esq., Duane Morris LLP **Date Prepared:**

Case Number (if known): 07-2762G **Issue: Whether the Intermediary erred in disallowing the Providers' Part A and Part B bad debts for services rendered to Medicare Beneficiaries.**

Provider Number	Provider Name/Location (city, county, state)	FYE	Intermediary	A Date of Final Determination	B Date of Appeal	C No. of Days	D Audit Adj. No.	E Amount of Reimbursement	F Original Case No.	G Date(s) of Add/ Transfer
12. 34-0129	Lake Norman Regional Medical Center Mooresville, Iredell County, North Carolina	09/30/05	Mutual of Omaha Insurance Company	06/19/07	12/06/07	170	15, 18	219,000	08-0374	02/19/08
13. 39-0061	Lancaster Regional Medical Center Lancaster, Lancaster County, Pennsylvania	06/30/05	Mutual Omaha Insurance Company	03/12/07	08/13/07	154	48, 54, 55	309,000	07-2654	09/11/07 09/20/07
14. 49-0012	Lee Regional Medical Center Pennington Gap, Lee County, Virginia	09/30/05	Mutual of Omaha Insurance Company	06/15/07	11/01/07	139	12	120,000	08-0163	12/12/07
15. 10-0107	Lehigh Regional Medical Center Lehigh Arces, Lee County, Florida	12/31/05	Mutual of Omaha Insurance Company	09/13/07	03/06/08	175	12, 16	160,000	08-1422	04/23/08

MODEL FORM G: SCHEDULE OF PROVIDERS IN GROUP

Group Name: HMA 2005 Bad Debt Group Appeal **Page 5 of 9**

Representative: Joanne B. Erde, Esq., Duane Morris LLP **Date Prepared:**

Case Number (if known): 07-2762G **Issue: Whether the Intermediary erred in disallowing the Providers' Part A and Part B bad debts for services rendered to Medicare Beneficiaries.**

	Provider Number	Provider Name/Location (city, county, state)	FYE	Intermediary	A Date of Final Determination	B Date of Appeal	C No. of Days	D Audit Adj. No.	E Amount of Reimbursement	F Original Case No.	G Date(s) of Add/ Transfer
16.	10-0150	Lower Keys Medical Center Key West, Monroe County, Florida	09/30/05	Mutual of Omaha Insurance Company	08/27/07	02/15/08	172	11, 15	153,000	08-1273	04/23/08
17.	25-0038	Madison Regional Medical Center Canton, Madison County, Mississippi	12/30/05	Mutual of Omaha Insurance Company	08/30/07	02/15/08	169	16, 25	57,000	08-1271	04/23/08
18.	37-0014	Medical Center of Southeast Oklahoma Durant, Bryan County, Oklahoma	09/30/05	Mutual of Omaha Insurance Company	08/28/07	02/06/08	162	15, 24, 26	323,000	08-1207	03/31/08
19.	49-0027	Mountain View Regional Medical Center Norton, Norton City, Virginia	12/31/05	Mutual of Omaha Insurance Company	05/22/07	11/01/07	163	18, 21	55,000	08-0165	12/12/07

MODEL FORM G: SCHEDULE OF PROVIDERS IN GROUP

Group Name: HMA 2005 Bad Debt Group Appeal **Page 6 of 9**

Representative: Joanne B. Erde, Esq., Duane Morris LLP **Date Prepared:**

Case Number (if known): 07-2762G **Issue: Whether the Intermediary erred in disallowing the Providers' Part A and Part B bad debts for services rendered to Medicare Beneficiaries.**

	Provider Number	Provider Name/Location (city, county, state)	FYE	Intermediary	A Date of Final Determination	B Date of Appeal	C No. of Days	D Audit Adj. No.	E Amount of Reimbursement	F Original Case No.	G Date(s) of Add/ Transfer
20.	25-0122	Natchez Community Hospital Natchez, Adam County, Mississippi	09/30/05	Mutual Omaha Insurance Company	03/05/07	08/14/07	162	14, 16	230,000	07-2642	09/11/07 09/20/07
21.	25-0042	Northwest Mississippi Regional Medical Center Clarksdale, Coahoma County, Mississippi	12/31/05	Mutual Omaha Insurance Company	03/02/07	08/13/07	164	29, 30	254,000	07-2647	09/11/07 09/20/07
22.	18-0078	Paul B. Hall Regional Medical Center Paintsville, Johnson County, KY	09/30/05	Mutual Omaha Insurance Company	09/12/07	03/04/08	174	16, 23	241,000	08-1221	09/02/08
23.	25-0096	Rankin Medical Center Brandon, Rankin County, Mississippi	12/31/05	Mutual Omaha Insurance Company	05/29/07	11/01/07	156	25	109,000	08-0164	12/12/07

MODEL FORM G: SCHEDULE OF PROVIDERS IN GROUP

Group Name: HMA 2005 Bad Debt Group Appeal **Page 7 of 9**

Representative: Joanne B. Erde, Esq., Duane Morris LLP **Date Prepared:**

Case Number (if known): 07-2762G **Issue: Whether the Intermediary erred in disallowing the Providers' Part A and Part B bad debts for services rendered to Medicare Beneficiaries.**

	Provider Number	Provider Name/Location (city, county, state)	FYE	Intermediary	A Date of Final Determination	B Date of Appeal	C No. of Days	D Audit Adj. No.	E Amount of Reimbursement	F Original Case No.	G Date(s) of Add/ Transfer
24.	25-0138	River Oaks Hospital Jackson, Rankin County, MS	12/31/05	Mutual of Omaha Insurance Company	03/07/07	08/13/07	159	18	132,000	07-2648	09/11/07 09/20/07
25.	10-0124	Santa Rosa Medical Center Milton, Santa Rosa County, Florida	05/31/05	Mutual of Omaha Insurance Company	03/01/07	08/13/07	165	12	128,000	07-2640	09/11/07 09/17/07
26.	10-0217	Sebastian River Medical Center Sebastian, Indian River County, Florida	09/30/05	Mutual of Omaha Insurance Company	03/02/07	08/14/07	165	9	150,000	07-2643	09/11/07 09/20/07
27.	10-0249	Seven Rivers Regional Medical Center Crystal River, Citrus County, Florida	05/31/05	Mutual of Omaha Insurance Company	09/12/07	03/04/08	174	15, 19	243,000	08-1220	03/31/08

MODEL FORM G: SCHEDULE OF PROVIDERS IN GROUP

Group Name: HMA 2005 Bad Debt Group Appeal Page 8 of 9

Representative: Joanne B. Erde, Esq., Duane Morris LLP Date Prepared:

Case Number (if known): 07-2762G Issue: Whether the Intermediary erred in disallowing the Providers' Part A and Part B bad debts for services rendered to Medicare Beneficiaries.

	Provider Number	Provider Name/Location (city, county, state)	FYE	Intermediary	A Date of Final Determination	B Date of Appeal	C No. of Days	D Audit Adj. No.	E Amount of Reimbursement	F Original Case No.	G Date(s) of Add/ Transfer
28.	04-0021	Southwest Regional Medical Center Little Rock, Pulaski County, AR	12/31/05	Mutual of Omaha Insurance Company	09/14/07	03/06/08	174	18, 21, 25	136,000	08-1420	04/23/08
29.	01-0038	Stringfellow Memorial Hospital Anniston, Calhoun County, Alabama	06/30/05	Mutual of Omaha Insurance Company	08/02/07	01/21/08	172	16, 17, 20, 21	33,000	08-0689	02/25/08
30.	50-0037	Toppenish Community Hospital Toppenish, Yakima County, Washington	06/30/05	Mutual of Omaha Insurance Company	03/05/07	08/14/07	162	16	26,000	07-2641	09/11/07 09/20/07
31.	44-0193	University Medical Center Lebanon, Wilson County, TN	10/31/05	Mutual of Omaha Insurance Company	03/07/07	08/13/07	159	23, 25	158,000	07-2646	09/11/07 09/20/07

MODEL FORM G: SCHEDULE OF PROVIDERS IN GROUP

Group Name: HMA 2005 Bad Debt Group Appeal **Page 9 of 9**

Representative: Joanne B. Erde, Esq., Duane Morris LLP **Date Prepared:**

Case Number (if known): 07-2762G **Issue: Whether the Intermediary erred in disallowing the Providers' Part A and Part B bad debts for services rendered to Medicare Beneficiaries.**

	Provider Number	Provider Name/Location (city, county, state)	FYE	Intermediary	A Date of Final Determination	B Date of Appeal	C No. of Days	D Audit Adj. No.	E Amount of Reimbursement	F Original Case No.	G Date(s) of Add/ Transfer
32.	51-0077	Williamson Memorial Hospital Williamson, Mingo County, West Virginia	09/30/05	Mutual of Omaha Insurance Company	08/30/07	02/15/08	169	15, 17	274,000	08-1270	04/23/08

SCHEDULE OF PROVIDERS IN GROUP

Group Name: HMA 2006 Bad Debt Group Appeal

Representative: Duane Morris LLP

Date Prepared: October 29, 2009; Revised December 23, 2009

Case Number (if known): 08-1704G

Issue: Whether the Intermediary erred in disallowing the Providers' Part A and Part B bad debts for services rendered to Medicare Beneficiaries.

					A	B	C	D	E	F	G
	Provider Number	Provider Name	Fiscal Year End	Intermediary	Date of Final Determination	Date of Hearing Request	No. of Days	Audit Adj. No.	Approx. Amount	Original Case No.	Date of Case Transfer
1.	11-0045	Barrow Regional Medical Center	12/31/06	Blue Cross and Blue Shield of Georgia	05/02/08	10/30/08	181	15, 17	90,969	09-0307	01/09/09
2.	10-0121	Bartow Regional Medical Center	03/31/06	Mutual of Omaha Insurance Company	09/20/07	03/06/08	168	9, 13	58,000	08-1419	03/31/08 04/23/08
3.	25-0007	Biloxi Regional Medical Center	09/30/06	Mutual of Omaha Insurance Company	02/05/08	07/18/08	164	26	267,000	08-2305	10/28/08
4.	10-0071	Brooksville Regional Medical Center	09/30/06	Mutual of Omaha Insurance Company	12/26/07	06/17/08	174	12, 15	185,000	08-2118	07/22/08

					A	B	C	D	E	F	G
	Provider Number	Provider Name	Fiscal Year End	Intermediary	Date of Final Determination	Date of Hearing Request	No. of Days	Audit Adj. No.	Approx. Amount	Original Case No.	Date of Case Transfer
5.		Left Blank Intentionally									
6.	42-0010	Carolina Pines Regional Medical Center	09/30/06	Mutual of Omaha Insurance Company	09/11/07	02/26/08	168	12, 15	433,000	08-1345	03/31/08 04/23/08
7.	25-0072	Central Mississippi Medical Center	03/31/06	Mutual of Omaha Insurance Company	08/29/07	02/15/08	170	35	466,000	08-1269	03/31/08 04/23/08
8.	42-0019	Chester Regional Medical Center	09/30/06	Wisconsin Physicians Service	02/04/08	07/18/08	165	22, 28	124,000	08-2299	10/28/08
9.	34-0144	Davis Regional Medical Center	09/30/06	Wisconsin Physicians Service	02/01/08	07/18/08	168	26, 31	184,000	08-2290	12/11/08
10.	11-0075	East Georgia Regional Medical Center	09/30/06	Mutual of Omaha Insurance Company	02/12/08	07/18/08	157	15, 22	221,000	08-2302	10/28/08
11.	10-0024	Fishermen's Hospital	09/30/06	Mutual of Omaha Insurance Company	01/18/08	07/10/08	174	12, 16	62,000	08-2358	10/28/08

					A	B	C	D	E	F	G
	Provider Number	Provider Name	Fiscal Year End	Intermediary	Date of Final Determination	Date of Hearing Request	No. of Days	Audit Adj. No.	Approx. Amount	Original Case No.	Date of Case Transfer
12.	34-0036	Franklin Regional Medical Center	09/30/06	Mutual of Omaha Insurance Company	02/19/08	07/18/08	150	9, 14	124,000	08-2301	10/28/08
13.	25-0025	Gilmore Regional Medical Center	12/31/06	Wisconson Physicians Service	03/28/08	09/19/08	175	13, 16	45,443	08-2841	09/19/08
14.	44-0144	Harton Regional Medical Center	05/31/06	Mutual of Omaha Insurance Company	09/17/07	03/06/08	171	10, 13	110,000	08-1415	03/31/08 04/23/08
15.	10-0137	Heart of Florida Regional Medical Center	06/30/06	Mutual of Omaha Insurance Company	09/18/07	03/06/08	170	10, 14	368,000	08-1413	03/31/08 04/23/08
16.	39-0068	Heart of Lancaster Regional Medical Center	06/30/06	Mutual of Omaha Insurance Company	08/16/07	01/23/08	160	8	103,000	08-0690	03/31/08
17.	10-0049	Highlands Regional Medical Center	09/30/06	Mutual of Omaha Insurance Company	02/07/08	07/18/08	162	13, 16	221,000	08-2303	10/28/08
18.	34-0129	Lake Norman Regional Medical Center	09/30/06	Wisconsin Physicians Service	03/13/08	09/04/08	175	13, 16	92,000	08-2836	09/04/08

					A	B	C	D	E	F	G
	Provider Number	Provider Name	Fiscal Year End	Intermediary	Date of Final Determination	Date of Hearing Request	No. of Days	Audit Adj. No.	Approx. Amount	Original Case No.	Date of Case Transfer
19.	39-0061	Lancaster Regional Medical Center	06/30/09	Wisconsin Physicians Service	05/09/08	11/03/08	178	39	149,676	09-0265	11/03/08
20.	10-0107	Lehigh Regional Medical Center	12/31/06	Wisconsin Physicians Service	04/30/08	10/14/08	167	12, 17	145,402	09-0077	10/14/08
21.	10-0150	Lower Keys Medical Center	09/30/06	Mutual of Omaha Insurance Company	02/22/08	07/18/08	147	21, 26, 36	160,000	08-2297	10/28/08
22.	25-0038	Madison Regional Medical Center	12/31/06	Mutual of Omaha Insurance Company	01/17/08	07/10/08	175	17	37,000	08-2357	10/28/08
23.	45-0031	Medical Center of Mesquite	03/31/06	TrailBlazer Health Enterprises, LLC	02/29/08	07/21/08	143	15, 17, 22	739,000	08-2310	10/17/08
24.	37-0014	Medical Center of SE Oklahoma	09/30/06	Mutual of Omaha Insurance Company	02/22/08	07/18/08	147	12, 20	208,000	08-2300	10/28/08
25.	45-0688	Mesquite Community Hospital	12/31/06	Wisconsin Physicians Service	03/20/08	09/11/08	175	18	386,000	08-2802	09/11/08

					A	B	C	D	E	F	G
	Provider Number	Provider Name	Fiscal Year End	Intermediary	Date of Final Determination	Date of Hearing Request	No. of Days	Audit Adj. No.	Approx. Amount	Original Case No.	Date of Case Transfer
26.	37-0094	Midwest City Regional Hospital	06/30/06	Mutual of Omaha Insurance Company	01/10/08	06/17/08	159	19, 23, 28	284,000	08-2115	07/22/08
27.	49-0027	Mountain View Regional Medical Center	12/31/06	Mutual of Omaha Insurance Company	02/22/08	07/18/08	147	16, 20	142,000	08-2298	10/28/08
28.		Left Blank Intentionally									
29.	25-0042	Northwest Mississippi Regional Medical Center	12/31/06	Wisconsin Physicians Service	05/08/2008	11/03/08	179	22	199,327	09-0264	11/03/08
30.	10-0211	Pasco Regional Medical Center	09/30/06	Wisconsin Physicians Service	08/01/08	01/09/09	161	13, 20	56,080	09-0577	01/09/09
31.	10-0077	Peace River Regional Medical Center	12/31/06	Wisconsin Physicians Service	04/25/08	10/14/08	172	17, 27	433,145	09-0081	10/14/08
32.	26-0119	Poplar Bluff Regional Medical Center	12/31/06	Wisconsin Physicians Service	10/14/08	03/30/09	166	20, 24, 25	283,218	09-1427	04/08/09

					A	B	C	D	E	F	G
	Provider Number	Provider Name	Fiscal Year End	Intermediary	Date of Final Determination	Date of Hearing Request	No. of Days	Audit Adj. No.	Approx. Amount	Original Case No.	Date of Case Transfer
33.	25-0096	Rankin Medical Center	12/31/06	Wisconsin Physicians Service	04/21/08	10/13/08	175	5,	176,359	09-0080	10/13/08
34.	25-0081	Riley Memorial Hospital	12/31/06	Wisconsin Physicians Service	03/20/08	09/11/08	175	16, 19, 26	219,000	08-2800	09/11/08
35.	01-0046	Riverview Regional Medical Center	06/30/06	Mutual of Omaha Insurance Company	05/01/07	10/22/07	174	3, 4, 18	390,000	08-0101	10/28/08
36.	10-0124	Santa Rosa Medical Center	05/31/06	Mutual of Omaha Insurance Company	09/21/07	03/11/08	172	16, 19	174,000	08-1392	03/31/08 04/23/08
37.	10-0217	Sebastian River Medical Center	09/30/06	Mutual of Omaha Insurance Company	02/22/08	07/18/08	147	10, 13	402,000	08-2296	10/28/08
38.	10-0249	Seven Rivers Regional Medical Center	05/31/06	Mutual of Omaha Insurance Company	09/18/07	03/06/08	170	16, 19, 25	288,000	08-1423	03/31/08 04/23/08
39.	04-0021	Southwest Regional Medical Center	12/31/06	Mutual of Omaha Insurance Company	05/08/08	11/03/08	179	20,25, 33	139,449	09-0263	01/09/09

					A	B	C	D	E	F	G
	Provider Number	Provider Name	Fiscal Year End	Intermediary	Date of Final Determination	Date of Hearing Request	No. of Days	Audit Adj. No.	Approx. Amount	Original Case No.	Date of Case Transfer
40.	01-0038	Stringfellow Memorial Hospital	06/30/06	Mutual of Omaha Insurance Company	08/22/07	02/09/08	171	11, 17	195,000	08-1206	03/31/08
41.	50-0037	Toppenish Community Hospital	06/30/06	Mutual of Omaha Insurance Company	10/19/07	04/01/08	165	16	18,000	08-1703	04/23/08
42.	26-0015	Twin Rivers Regional Medical Center	12/31/06	Wisconsin Physicians Service	05/19/08	11/06/08 11/12/08	171	19, 22, 28, 33	51,022		
43.	44-0193	University Medical Center	10/31/06	Wisconsin Physicians Service	03/04/08	08/13/08	162	24, 29, 45	117,000	08-2745	01/09/09
44.	10-0070	Venice Regional Medical Center	12/31/06	Mutual of Omaha Insurance Company	02/01/08	07/18/08	168	6	125,500	08-2307	10/28/08
45.	11-0046	Walton Regional Medical Center	09/30/06	Mutual of Omaha Insurance Company	02/06/08	07/18/08	163	15, 20	222,000	08-2304	10/28/08

					A	B	C	D	E	F	G
	Provider Number	Provider Name	Fiscal Year End	Intermediary	Date of Final Determination	Date of Hearing Request	No. of Days	Audit Adj. No.	Approx. Amount	Original Case No.	Date of Case Transfer
46.	51-0077	Williamson Memorial Hospital	09/30/06	Wisconsin Physicians Service	03/10/08	09/04/08	178	18	244,000	08-2837	09/04/08
47.	25-0136	Woman's Hospital at River Oaks	12/31/06	Wisconsin Physicians Service	03/19/08	09/10/08	175	14	20,000	08-2801	09/10/08
48.	50-0012	Yakima Regional Medical Center	06/30/06	Mutual of Omaha Insurance Company	11/21/07	05/02/08	163	1, 25, 26	135,000	08-1944	07/22/08