PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

ON THE RECORD
2013-D23

PROVIDER –
QRS DSH Florida/General Assistance Days Groups

Provider Nos.: See Appendix A

vs.

INTERMEDIARY –
BlueCross Blue Shield Association/
First Coast Service Options, Inc.-FL

DATE OF HEARING -
May 15, 2013

Cost Reporting Periods Ended -
See Appendix A

CASE NOs.: 07-2057G; 07-2058G; 07-2059G; 07-2060G; 07-2061G; 07-2308G and 09-1563G

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ISSUE:

Whether the Intermediary properly excluded Medicaid eligible Florida Charity Care and Low-Income days from the disproportionate share hospital ("DSH") calculation.

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 ("Act"),[1] to provide health insurance to the aged and disabled. The Centers for Medicare & Medicaid Services ("CMS"), formerly the Health Care Financing Administration ("HCFA"), is the operating component of the U.S. Department of Health and Human Services ("DHHS") charged with administering the Medicare program. CMS' payment and audit functions under the Medicare program are contracted to organizations known as fiscal intermediaries ("FIs") and Medicare administrative contractors ("MACs"). FIs and MACs[2] determine payment amounts due the providers under Medicare law, regulation and interpretative guidelines published by CMS.[3]

Providers are required to submit cost reports annually, with reporting periods based on the provider's accounting year. A cost report shows the costs incurred during the relevant fiscal year and the portion of those costs allocated to the Medicare program.[4] Each 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").[5] 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.[6]

Part A of the Medicare program covers "inpatient hospital services". Since 1983, the Medicare program has paid most hospitals for the operating costs of inpatient hospital services under the inpatient prospective payment system ("IPPS").[7] Under IPPS, the Medicare program pays predetermined, standardized amounts per discharge, subject to certain payment adjustments.[8]

The statutory provisions addressing IPPS are located in § 1886 of the Act[9] and they contain a number of provisions that adjust payment based on hospital-specific factors.[10] This case involves the hospital-specific DSH adjustment specified in § 1886(d)(5)(F)(i)(I). This provision

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[1] Title XVIII of the Act was codified at 42 U.S.C. Ch. 7, Subch. XVIII.
[2] FIs and MACs are hereinafter referred to as intermediaries.
[3] *See* §§ 1816 and 1874A of the Act, 42 U.S.C. § 1395h and § 1395kk-1; 42 C.F.R. §§ 413.20 and 413.24.
[4] *See* 42 C.F.R. § 413.20.
[5] *See* 42 C.F.R. § 405.1803.
[6] *See* § 1878(a) of the Act, 42 U.S.C. § 1395oo(a); 42 C.F.R. §§ 405.1835-405.1837.
[7] *See* § 1886(d) of the Act, 42 U.S.C. § 1395ww(d); 42 C.F.R. Part 412.
[8] *See* § 1886(d) of the Act, 42 U.S.C. § 1395ww(d); 42 C.F.R. Part 412.
[9] 42 U.S.C. § 1395ww(d).
[10] *See* § 1886(d)(5) of the Act, 42 U.S.C. § 1395ww(d)(5).

requires the Secretary to provide increased IPPS payments to hospitals that serve a significantly disproportionate number of low-income patients.[11]

A hospital may qualify for a DSH adjustment based on its disproportionate patient percentage ("DPP").[12] The DPP is a proxy for utilization by low-income patients and determines a hospital's qualification as a DSH. It also determines the amount of the DSH payment to a qualifying hospital.[13]

The DPP is defined as the sum of two fractions expressed as percentages.[14] Those two fractions are referred to as the "Medicare/SSI" fraction and the "Medicaid" fraction. The Medicare/SSI fraction is defined in § 1886(d)(5)(F)(vi)(I) as:

> [T]he fraction (expressed as a percentage), the numerator of which is the number of such hospital's patient days for such period which were made up of patients who (for such days) were entitled to benefits under part A of this title and were entitled to supplemental security income benefits (excluding any State supplementation) under title XVI of this Act, and the denominator of which is the number of such hospital's patient days for such fiscal year which were made up of patients who (for such days) were entitled to benefits under part A of this title, ...

The Medicare/SSI fraction is computed annually by CMS, and intermediaries use CMS' calculation to compute the DSH payment adjustment as relevant for each hospital.[15]

Similarly, the Medicaid fraction (also referred to as the Medicaid proxy) is defined in § 1886(d)(5)(F)(vi)(II) as:

> [T]he fraction (expressed as a percentage), the numerator of which is the number of the hospital's patient days for such period which consist of patients who (for such days) were *eligible for medical assistance under a State plan approved under title XIX*, but who were not entitled to benefits under part A of this title, and the denominator of which is the total number of the hospital's patient days for such period.[16]

The intermediary determines the number of the hospital's patient days of service for which patients were eligible for medical assistance under a State plan approved under Title XIX but not

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[11] *See also* 42 C.F.R. § 412.106.
[12] *See* §§ 1886(f)(d)(5)(F)(i)(I) and (d)(5)(F)(v) of the Act, 42 U.S.C. §§ 1395ww(d)(5)(F)(i)(I) and (d)(5)(F)(v); 42 C.F.R. § 412.106(c)(l).
[13] *See* §§1886(d)(5)(F)(iv) and (d)(5)(F)(vii)-(xiv) of the Act, 42 U.S.C. §§ 1395ww(d)(5)(F)(iv) and (vii)-(xiv); 42 C.F.R. § 412.106(d).
[14] *See* § 1886(d)(5)(F)(vi), 42 U.S.C. § 1395ww(d)(5)(F)(vi).
[15] 42 C.F.R. §§ 412.106(b)(2)-(3).
[16] (Emphasis added.)

entitled to Medicare Part A, and divides that number by the total number of patient days in the same period.[17]

The patient days eligible for inclusion in the Medicaid fraction under the Title XVIII Medicare DSH statute is the only issue in these cases. However, resolution of the Medicare DSH issue involves the interpretation of a similar Medicaid DSH provision found in Title XIX of the Act and whether it applies to the Medicare DSH Medicaid fraction. The details of the Medicaid DSH provisions are discussed in more detail below.

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

This case includes 7 group appeals, collectively known as the QRS DSH/Florida General Assistance Days Groups (the "Providers").[18] The Providers in these group appeals are all acute care hospitals located in Florida that received payment under Medicare Part A for services to Medicare beneficiaries for cost reporting periods from 1994 through 2008. The Providers participated in the Florida State Plan which provides medical assistance to uninsured low-income patients not eligible for other medical assistance programs, including Medicaid.[19]

During the years in question, the intermediary was First Coast Service Options, Inc. ("FCSO" or "Intermediary"). The Intermediary issued NPRs for the Providers' cost reporting periods at issue without including Florida Charity Care[20] days in the Medicaid fraction of the Providers' Medicare DSH calculations. The Providers timely appealed the Intermediary's determinations to the Board.

The Providers were represented by J.C. Ravindran, Quality Reimbursement Services, Inc. The Intermediary was represented by Arthur E. Peabody, Esq., of the BlueCross BlueShield Association.

BACKGROUND ON INCLUSION OF FLORIDA CHARITY CARE DAYS IN THE MEDICAID PERCENTAGE OF THE MEDICARE DSH ADJUSTMENT:

The parties agree that resolution of the issue before the Board hinges on the meaning of the phrase "patients who for such days were eligible for medical assistance under a State plan approved under [T]itle XIX" as used in § 1886(d)(5)(F)(vi)(II)[21]" to describe the Medicaid fraction. This phrase identifies those days that are to be counted in the Medicaid proxy of the Medicare DSH adjustment.

Title XIX of the Act provides for federal sharing of state expenses for medical assistance for low-income individuals under the Medicaid program, provided the state Medicaid program meets

[17] 42 C.F.R. § 412.106(b)(4).
[18] *See* Appendix A for a summary of Providers by Group.
[19] *See* http://www.fdhc.state.fl.us/Medicaid/stateplan.shtml.
[20] Charity care is direct patient care provided by one or more hospitals in Florida. Hospitals may receive payments from the state for this care which may be reimbursed through disproportionate share payments by the federal Medicaid program. *See* Florida State Plan Under Title XIX of the Social Security Act, Attachment 4.19-A at III.H.s.g (excerpt quoted in Provider's Final Position Paper at Exhibit 1).
[21] 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II).

certain provisions contained Title XIX. The state must submit a plan describing the state Medicaid program and seek approval from the Secretary.[22] If approved, the state may claim federal matching funds, known as federal financial participation ("FFP") under Title XIX for the services provided and approved under the state Medicaid program.

PARTIES' CONTENTIONS:

The Providers contend that the Medicare statute and regulations require the inclusion of the Florida Charity Care days in the Medicare DSH calculation because the charity care program was a part of the Florida State Medicaid Plan and CMS reviewed and approved that plan. The Providers state that the charity care funding relies on Medicaid dollars for which the State receives federal matching funds. The Providers also argue that the term "medical assistance" is broad in scope and includes all services and payments for services made under the state Medicaid plan, including Medicaid DSH payments. Thus, the Florida Charity Care must be considered "medical assistance under a State plan," and all days related to providing care for charity care patients must be included in the Providers' DSH calculations.

Finally, the Providers assert that, even though the case law on this issue generally does not support the Providers' position, the better reasoned decisions are the ones that do support their position. In this regard, the Providers rely primarily on the decisions of *Portland Adventist Med. Ctr. v. Thompson*, 399 F.3d 1091 (9th Cir. 2005) ("*Portland Adventist*") and *Legacy Emanuel Hosp. & Health Ctr. V. Shalala*, 97 F.3d. 1261 (9th Cir. 1996).[23]

The Providers assert that the Ninth Circuit decision in *Portland Adventist* supports the inclusion of expansion population patient days. While the Providers acknowledge that waiver 1115 expansion days are different from a program included in a State Plan, the results are the same – Title XIX funds are providing medical assistance to low-income patients.

The Providers also argue that Program Memorandum ("PM") A-99-62[24] permits inclusion of Low-Income and Charity Care days in the DSH calculation. The Providers contend that CMS arbitrarily allowed only the following providers to be "held harmless" and retain or obtain the additional funding: (1) providers that had previously received payment based upon what CMS considered to be the prior erroneous inclusion of strictly state funded programs; and (2) those providers which had appealed the exclusion of state-only programs prior to October 15, 1999. This policy results in similarly situated providers being treated in a dissimilar manner and is arbitrary.

The Providers disagree with the District of Columbia Circuit court decision in *Adena Reg'l Med. Ctr. v. Leavitt*, 527 F.3d 176 (D.C. Cir. 2008), *cert. denied*, 129 S. Ct. 1933 (2009) ("*Adena*"). The Providers argue that the facts in *Adena* are not present in the subject appeal. In *Adena*, the D.C. Circuit's holding was based on the fact that, under the Ohio Hospital Care Assurance Program ("HCAP"), the State of Ohio did not reimburse hospitals for the cost of providing

[22] *See* 42 U.S.C. § 1396a.
[23] *See* Providers' Final Position Paper at 17 and 19.
[24] CMS Pub. 60-A, Transmittal A-99-62 (Dec. 1, 1999) (later re-issued as CMS Pub 60-A, Transmittal A-01-13 (Jan. 25, 2001)).

mandatory charity care. By contrast, the Providers argue, the Florida State plan does provide payment to hospitals for inpatient services for individuals who qualify as low-income or charity care.

The Providers argue that the *Adena* decision is flawed because it links the Medicaid and Medicare statutes together without Congressional authority to do so. Further, the Providers disagrees with the *Adena* court's use of the Medicaid DSH statutory language as a touchstone for interpreting the Medicare DSH statute simply because both provisions use of the terms "medical assistance" and serve the same general purpose, *i.e.*, to compensate hospitals for rendering a disproportionate amount of care to low-income patients.[25]

The Intermediary counters that days of care paid for by programs for low income patients who are not eligible for Medicaid – even if the programs are cited in the State plan approved by Medicaid – cannot be included. The Intermediary reasons that, because the Florida State Medicaid Plan requires patients who are eligible for the Florida Charity Care Program be first determined ineligible for Medicaid, Florida Charity Care days must be excluded from the Medicaid proxy of the Medicare DSH calculation.

The Intermediary also maintains that only certain providers can be held harmless under the terms of PM A-99-62. The Intermediary asserts that it is simply an issue of whether the particular provider meets the stated criteria, and these Providers in this case do not. In support of its position, the Intermediary primarily relies on *United Hosp. v.Blue Cross Blue Shield Ass'n*, PRRB Dec. No. 2002-D23 (June 27, 2002), *review declined*, CMS Administrator memorandum (Aug. 12, 2002). In this case, the Board reached the following conclusion:

> The Board finds that the Provider is not entitled to include State-Only program days in its DSH calculation for FYs 1992 and 1993. The Board notes that the New Policy contained in Program Memorandum A-99-62 provides relief in certain situations for certain providers to receive reimbursement for the State-Only days. Since the Provider did not "fit" into any of the groups outlined in the Program Memorandum, the Board finds that the statute, which outlines the intent of DSH is the controlling law in this case . . . .[26]

The Intermediary also relies on HCFA Ruling 97-2 which indicates that CMS allows only for Medicaid eligible days to be included in the Medicaid fraction.[27] Furthermore, PM A-99-62 excludes Charity Care Days, General Assistance days, *etc.*, from being included in the Medicaid fraction.[28]

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[25] Providers' Supplemental Position Paper at 21-22.
[26] ~~*See* Intermediary Exhibit I-3.~~
[27] *See* Intermediary Final Position Paper at 5.
[28] *See* Intermediary Exhibit I-2.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board has considered the Medicare law and program instructions, the evidence presented and the parties' contentions. Set forth below are the Board's findings and conclusions.

The evidence establishes that Florida Charity Care beneficiaries are not eligible for Medicaid and the services provided under that program are not matched with federal funds *except* under the Medicaid DSH provisions.

The Medicaid DSH provisions are similar to the Medicare DSH provisions. Section 1923(a) of the Act[29] mandates that a state Medicaid plan under Title XIX must include a provision for a payment adjustment to hospitals which serve a disproportionate number of low income patients, *i.e.*, it requires a Medi*caid* DSH adjustment for hospitals that is independent of the Medi*care* DSH adjustment at issue in this case. The Medicaid DSH adjustment is eligible for FFP even though the particular patient days counted for Medicaid DSH are not directly eligible for FFP because they do not qualify as "traditional Medicaid" services described in § 1905(a).

The question for the Board is whether the Florida Charity Care program as a state funded program not otherwise eligible for Medicaid coverage and that is included in the Florida State Medicaid Plan solely for the purpose of calculating the Medi*caid* DSH payment constitutes "medical assistance under a State plan approved under [T]itle XIX" for purposes of the Medi*care* DSH adjustment, specifically in the Medicaid fraction component.

In prior decisions on similar state funded programs, the Board has interpreted the Medicare statutory phrase "medical assistance under a State plan approved under [T]itle XIX" to include any program identified in the approved state plan, *i.e.*, it has not limited the days counted to traditional Medicaid days.[30] Subsequent to those decisions, the U.S. Court of Appeals for the District of Columbia issued its decision in *Adena Reg'l Med. Ctr. v. Leavitt*,[31] and concluded that the days related to beneficiaries eligible for HCAP should not be included in the Medicaid proxy of the Medicare DSH calculation.[32] Like the Florida Charity Care program, HCAP patients could not qualify for Medicaid but the HCAP days were included in the Medicaid DSH calculation. The D.C. Circuit pointed out that § 1923(c)(3)(B) of the Act[33] "permits the states to adjust DSH payments 'under a methodology that' considers *either* 'patients eligible for medical assistance under a State plan approved under [Medicaid] or … low-income patients,' 42 U.S.C. § 1396r-4(c)(3)(B), such as those served under the HCAP."[34]

Upon further review and analysis of § 1923, the Board is persuaded and finds that the term "medical assistance under a state plan approved under [T]itle XIX" excludes days funded by only the state and charity care days even though those days may be counted for Medicaid DSH purposes.

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[29] 42 U.S.C. § 1396r-4(a).
[30] *See, e.g., Ashtabula County Med. Ctr. v. Blue Cross Blue Shield Ass'n,* PRRB Dec. No. 2005-D49 (Aug. 10, 2005), *rev'd*, CMS Administrator Dec. (Oct. 12, 2005).
[31] 527 F 3d 176 (D.C. Cir., 2008), *cert. denied,* 129 S. Ct. 1933 (2009).
[32] *Adena*, 527 F.3d at 180.
[33] 42 U.S.C. § 1396r-4(c)(3)(B).
[34] *Adena*, 527 at 180 (brackets, ellipses, and citation in original; footnote and italics emphasis added.)

Title XIX describes how hospitals qualify for the Medicaid DSH adjustment. Specifically, § 1923(b) establishes two distinct categories of low-income patients that are used to calculate a Medicaid DSH payment. The two categories, identified as the "Medicaid inpatient utilization rate" and the "low-income utilization rate," are defined in subsection (b)(2) and (b)(3), in pertinent part, as follows:

> (b)(2) For purposes of paragraph (1)(A), the term "medicaid inpatient utilization rate" means, for a hospital, a fraction (expressed as a percentage), the numerator of which is the hospital's number of inpatient days attributable to patients who (for such days) were *eligible for medical assistance under a State plan approved under this title* [*i.e.*, Title XIX of the Act] in a period ... , and the denominator of which is the total number of the hospital's inpatient days in that period. . . .
> (b)(3) For purposes of paragraph (1)(B), the term "low-income utilization rate" means, for a hospital, the sum of –
>
> (A) the fraction (expressed as a percentage)-
> (i) the numerator of which is the sum (for a period) of (I) the total revenues paid the hospital for *patient services under a State plan* under this title ... and (II) the amount of the *cash subsidies for patient services received directly from State and local governments*, and
> (ii) the denominator of which is the total amount of revenues of the hospital for patient services (including the amount of such cash subsidies) in the period; and
>
> (B) a fraction (expressed as a percentage)-
> (i) the numerator of which is the total amount of the hospital's charges for inpatient hospital services which are attributable to charity care in a period, less the portion of any cash subsidies described in clause (i)(II) of subparagraph (A) in the period reasonably attributable to inpatient hospital services, and
> (ii) the denominator of which is the total amount of the hospital's charges for inpatient hospital services in the hospital in the period. . . .[35]

Subsection (b)(2) specifically uses the term "eligible for medical assistance under a State plan," the exact language from the Medicare DSH statute relevant to this case. That phrase describes the days included in the "Medicaid inpatient utilization rate" for the Medicaid DSH adjustment.

It is the second category, the "low-income utilization rate," that clarifies what is and what is not included in "medical assistance under a State plan." Subsection (b)(3) defines the term "low-income utilization rate" to include three components. In paragraph (A)(i)(I) of this subsection,

[35] (Emphasis added.)

there is the first component consisting of "services [furnished] under a State plan under this title [XIX]," the same category of patients described in the Medicaid utilization rate. In paragraphs (A)(i)(II) and (B)(i), the second and third components include "cash subsidies for patient services received directly from State and local governments" and "charity care" respectively. If Congress had intended the term "eligible for medical assistance under a State plan" (the only category of patients in the Medicaid utilization rate) to include the state funded hospital days and charity care days, the subsections adding those types of days in the "low income utilization rate" would have been superfluous.

Based on the above, the Board concludes that, because the Florida Charity Care program is funded by "state and local governments" and, thus, is included in the low income utilization rate but not the Medicaid inpatient utilization rate, Florida Charity Care patient days do not fall within the Medicaid DSH statute definition of "eligible for medical assistance under a State plan" at § 1923(b)(2) of the Act.[36] Statutory construction principles require the Board to apply the meaning Congress ascribed to the term "eligible for medical assistance under a State plan" used in the Medicaid statute to the same phrase used in the Medicare statute.[37] Florida Charity Care patient days, therefore, cannot be included in the Medicare DSH statutory definition of "eligible for medical assistance under a State plan" at § 1886(d)(5)(F)(vi)(II) of the Act.[38] Accordingly, the Intermediary's adjustments properly excluded Florida Charity Care program patient days from the Providers' Medicare DSH calculations.

DECISION AND ORDER:

The Intermediary properly refused to include Florida Charity Care Program days in the numerator of the Providers' Medicaid proxy. The Intermediary's adjustments are affirmed.

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[36] 42 U.S.C. § 1396r-4(b)(2). On July 23, 2012, as part of a Board submission for this case, the Provider Representative informed the Board of the following case involving a GA days DSH issue – *Nazareth Hosp. v. Sebelius*, Civ. Action No. 10-3513 (E.D. Pa.) ("*Nazareth*"). Subsequent to the Board receipt of this submission, a decision was issued in *Nazareth*. *See Nazareth*, Civ. Action No. 10-3513, 2013 WL 1401778 (E.D. Pa. Apr. 8, 2013). However, concurrent with this decision, the Board sent a letter to the Provider Representative confirming that the Board would neither consider the *Nazareth* case nor enter into the record any additional arguments and evidence regarding *Nazareth* included or requested in that submission because: (1) the *Nazareth* case presents new legal arguments under the Equal Protection Clause of the Constitution and Administrative Procedure Act (*see id.* at *2, *12 n.1) that were not raised by the Provider prior to the closing of the record on August 12, 2011 (indeed, none of these arguments would be ones that the Board would be authorized to consider pursuant to 42 C.F.R. § 405.1867 and the *Nazareth* case is not binding precedent on the Board); and (2) the Provider through the Provider Representative failed to properly preserve its right to make these arguments and evidence a part of the record for the record hearing because, in attempting to obtain Board consideration of new argument and evidence (as well as a request to admit yet more evidence) related to *Nazareth*, the Provider Representative failed to observe and comply with Board Rules 32.3(C) and 44.1-44.3 specifying the duty to confer with the other party and the proper process and procedure to petition the Board by written motion to reopen the record for a record hearing for additional argument and evidence.

[37] *See Atlanta Cleaners & Dyers, Inc. v. U.S.*, 286 U.S. 427, 433 (1932).

[38] 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II).

BOARD MEMBERS PARTICIPATING:

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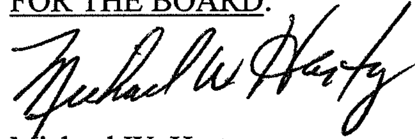

Michael W. Harty
Chairman

DATE: JUL 31 2013

APPENDIX A
SUMMARY OF PROVIDERS BY GROUP

Case No.: 07-2057G
Group Name: QRS 2000 DSH Florida/General Assistance Days Group
Lead Intermediary: First Coast Service Options, Inc.-FL

	Provider No.	Provider Name	FYE
1		Provider removed [39]	
2	10-0018	Naples Community Hospital	09/30/1997
3	10-0018	Naples Community Hospital	09/30/1998
4	10-0018	Naples Community Hospital	09/30/1999
5	10-0018	Naples Community Hospital	09/30/2000
6	10-0052	Winter Haven Hospital	09/30/2000
7	10-0084	Leesburg Regional Medical Center	06/30/2000
8	10-0105	Indian River Memorial Hospital	09/30/2000

Case No.: 07-2058G
Group Name: QRS 2001 DSH Florida/General Assistance Days Group
Lead Intermediary: First Coast Service Options, Inc.-FL

	Provider No.	Provider Name	FYE
1	10-0002	Bethesda Memorial Hospital	09/30/2001
2	10-0018	Naples Community Hospital	09/30/2001
3	10-0052	Winter Haven Hospital	09/30/2001
4	10-0084	Leesburg Regional Medical Center	06/30/2001
5	10-0093	Baptist Hospital	09/30/2001
6	10-0105	Indian River Memorial Hospital	09/30/2001

Case No.: 07-2059G
Group Name: QRS 2002 DSH Florida/General Assistance Days Group
Lead Intermediary: First Coast Service Options, Inc.-FL

	Provider No.	Provider Name	FYE
1	10-0002	Bethesda Memorial Hospital	09/30/2002
2	10-0052	Winter Haven Hospital	09/30/2002
3	10-0084	Leesburg Regional Medical Center	06/30/2002
4	10-0092	Wuesthoff Memorial Hospital	09/30/2002
5	10-0105	Indian River Memorial Hospital	09/30/2002

[39] Naples Community Hospital, Provider No. 10-0018, FYE 09/30/1994 was removed from CN 07-2057G based on the Board's jurisdictional review dated July 23, 2013.

APPENDIX A
SUMMARY OF PROVIDERS BY GROUP

Case No.: 07-2060G
Group Name: QRS 2003 DSH Florida/General Assistance Days Group
Lead Intermediary: First Coast Service Options, Inc.-FL

	Provider No.	Provider Name	FYE
1	10-0052	Winter Haven Hospital	09/30/2003
2	10-0084	Leesburg Regional Medical Center	06/30/2003
3	10-0105	Indian River Memorial Hospital	09/30/2003

Case No.: 07-2061G
Group Name: QRS 2004 DSH Florida/General Assistance Days Group
Lead Intermediary: First Coast Service Options, Inc.-FL

	Provider No.	Provider Name	FYE
1	10-0084	Leesburg Regional Medical Center	06/30/2004
2	10-0105	Indian River Memorial Hospital	09/30/2004

Case No.: 07-2308G
Group Name: QRS 1996 DSH Florida/General Assistance Days Group
Lead Intermediary: First Coast Service Options, Inc.-FL

	Provider No.	Provider Name	FYE
1	10-0018	Naples Community Hospital	09/30/1996
2	10-0084	Leesburg Regional Medical Center	06/30/1996

APPENDIX A
SUMMARY OF PROVIDERS BY GROUP

Case No.: 09-1563G
Group Name: QRS 2005-2006 DSH Florida/General Assistance Days Group
Lead Intermediary: First Coast Service Options, Inc.-FL

	Provider No.	Provider Name	FYE
1	10-0001	Shands Jacksonville Medical Center	06/30/2005
2	10-0052	Winter Haven Hospital	09/30/2005
3	10-0001	Shands Jacksonville Medical Center	09/30/2006
4	10-0002	Bethesda Memorial Hospital	09/30/2006
5	10-0018	Naples Community Hospital	09/30/2006
6	10-0052	Winter Haven Hospital	09/30/2006
7	10-0084	Leesburg Regional Medical Center	06/30/2006
8	10-0105	Indian River Memorial Hospital	09/30/2006
9	10-0105	Indian River Memorial Hospital	09/30/2007
10	10-0084	Leesburg Regional Medical Center	06/30/2008
11	10-0092	Wuesthoff Memorial Hospital	09/30/2008