CENTERS FOR MEDICARE & MEDICAID SERVICES

Decision of the Administrator

In the case of:	Claim for:
Rush-Presbyterian-St. Luke's Medical Center **Provider** **vs.** **Blue Cross /Blue Shield Association** **AdminiStar Federal, Inc.** **Intermediary**	**Provider Cost Reimbursement Determination for Cost Reporting Period Ending: June 30, 1991** **Review of:** **PRRB Dec. No. 2006-D5** **Dated: November 18, 2005**

This case is before the Administrator, Centers for Medicare & Medicaid Services (CMS), for review of the decision of the Provider Reimbursement Review Board (Board). The review is during the 60-day period in §1878(f) (1) of the Social Security Act (Act), as amended (42 USC 1395oo (f)). The Center for Medicare Management (CMM) submitted comments requesting reversal of the Board's decision on Issues Nos. 1 and 3. CMM also requested that the Administrator modify the Board's decision on Issue No. 2 Accordingly, the parties were notified of the Administrator's intention to review the Board's decision on all three issues. Comments were received from the Intermediary on Issue Nos. 1 and 3 requesting reversal of the Board's decision. The Provider submitted comments on Issue Nos. 1 and 3 requesting that the Administrator reverse the Board's decision. The Provider requested that the Administrator modify the Board's decision on Issue No. 2. All comments were timely received. Accordingly, this case is now before the Administrator for final agency review.

BACKGROUND

Issue No. 1 – Disproportionate Share Hospital Calculation

Relevant to this case, CMS Program Memorandum (PM) A-99-62 was issued to clarify the definition of eligible Medicaid days in the Medicare disproportionate share hospital (DSH) calculation. In addition, it memorialized a "hold harmless" policy, previously communicated on October 15, 1999, for cost reporting periods beginning before January 1, 2000. The PM

instructed intermediaries regarding hospitals that did not receive payments reflecting the erroneous inclusion of general assistance or other State-only health program charity care, Medicaid DSH, and/ or waiver or demonstration population days for cost reports that were settled before October 15, 1999. The intermediary was to include those days as Medicaid days if a Provider had filed a jurisdictionally proper appeal to the Board "on the issue of the exclusion of these types of days from the Medicare DSH formula before October 15, 1999".

In this case, the Provider seeks application of the "hold harmless" policy for its DSH payment calculation for fiscal year ending (FYE) 1991. The Provider did not claim general assistance days (also referred to as GA days) in its cost report. After October 15, 1999, the Provider added the issue of GA days to its appeal for this cost year. The Intermediary argues that the Provider does not qualify for the "hold harmless" provisions of PM A-99-62.

Issue No. 2 – Graduate Medical Education

The Intermediary disallowed a number of full-time equivalent (FTE) residents claimed by the Provider because the residents participated in a medical education fellowship program that was not approved pursuant to 42 C.F.R. §413.86(b). The Intermediary also disallowed FTEs associated with three specific residents for GME purposes and five specific residents for IME for different documentation concerns. The Intermediary disallowed .33 of an FTE associated with Dr. R. Lakshman because Dr. R. Lakshman was not in an initial residency period and because Dr. R. Lakshman's resume placed him at Loyola University Medical Center during the subject cost reporting period, as opposed to being at the Provider's facility.

The Intermediary disallowed the entire FTE associated with Dr. H. Abusharif for GME purposes, because the rotation scheduled placed him at Christ Hospital during the cost reporting period, as opposed to being at the Provider's facility.

The Intermediary disallowed the entire FTE associated with Dr. Soltes, for GME purposes because the resident had not received certification from the Educational Commission for Foreign Medical Graduates (ECFMG).

The Intermediary initially disallowed FTEs associated with Drs. Wong and Myles because they participated in an unapproved program. However, the Intermediary later allowed 1.5 FTEs for GME based upon a certification statement received from the program director explaining that the residents participated in an approved program in maternal/fetal medicine. The Intermediary however, disallowed FTEs for IME associated with Drs. Wong and Myles because the Provider could not document that on September 4, 1990, the day for counting residents for IME that Drs. Wong and Myles did not work in a non-allowable area of the hospital.

The Intermediary denied FTEs associated with Drs. Kaskel and Abrams because their rotation schedules showed that they were assigned to allergy/immunology area on September 4, 1990 and because the Provider disclosed that another resident assigned to that area had been improperly claimed for IME purposes when in fact they worked in a non-allowable outpatient department.

Finally, the Intermediary denied an FTE associated with Dr. Muhsin for the IME purposes because he rotated through a non-allowable area, the Johnson R. Newman Rehabilitation Center (JRN).

Issue No. 3 – Inn at University Village

The Provider operated a full-service hotel called the Inn at University Village (Inn).[1] For the fiscal period in dispute, the Provider claimed costs under the belief that the activities at the Inn were patient care related. Specifically, the Provider claimed costs related to the Inn for direct operating expenses incurred (net of revenues), depreciation, taxes, interest and amortization. For FYE 1991, the Provider claimed the Inn produced a net operating loss of $278,917.[2] Upon review, the Intermediary disallowed all expenses related to the Inn on the basis that they were not related to patient care.[3] Included in this disallowance was an adjustment relating to interest expense from an Illinois Educational Facilities Authority (IEFA) bond issue.

The Provider initially appealed on the grounds that the Inn was related to patient care and, therefore, a percentage of the expenses associated with the Inn's operations should be included on the cost report as an allowable expense. However, the Provider now argues that the resulting net loss incurred by the Provider should be offset against investment income in calculating the amount of allowable interest for the Provider. Furthermore, the Intermediary erred in disallowing interest expense related to the IEFA bond issue. The Provider argued that the proceeds of the IEFA bond issue were used for facilities and operations related to inpatient and outpatient facilities, directly related to patient care and not for the construction of the Inn.

ISSUES AND BOARD'S DECISION

[1] Provider's Revised Brief at 31. The Inn is a 114-room full-service hotel which provides accommodations, meeting rooms and restaurant.
[2] Provider's Exhibit P-43. The Intermediary, in the alternative, raised issue with the amount of the Provider's calculation of the operating loss.
[3] Id.

ISSUE NO. 1

Issue No. 1 is whether the Intermediary's adjustment to the Provider's disproportionate share (DSH) payment was proper.

The Board held that the Provider failed to meet the requirements of HFCA Ruling 97-2 dated February 27, 1997, because the Provider did not challenge the exclusion of GA days in the fiscal period in dispute. However, the Board determined that the Provider qualified for the "hold harmless" provision of PM A-99-62, because the Provider had appealed the exclusion of GA days in 1989 and 1990 cost reporting periods. (PRRB Case Nos. 92-1678 and 92-1717). The Board disagreed with the Intermediary's argument that the Provider's 1989 and 1990 appeal had no application to the instant case because they were settled through an Administrative Resolution which made no payment to the Provider for GA days in its DSH determinations. The Board concluded that the qualifying factor for the "hold harmless policy" was a history of appealing the exclusion of GA days, whether or not payment was made for those days. Therefore, the Board reversed the Intermediary's determination and remanded the matter to the Intermediary to verify the number of State-only GA days to be included in the Provider's DSH formula and to recalculate the Provider's DSH payment with the inclusion of those days.

ISSUE NO. 2

Issue No. 2 is whether the Intermediary's calculation of the number of interns and residents and the amount of allowable costs for fiscal year 1991 for purposes of the Graduate Medical Education (GME) Programs (both for purposes of GME and IME) was proper.

The Board held that the FTEs disallowed by the Intermediary were proper with one exception, that being the FTEs associated with the Provider's neuroradiology program. The Board concluded that the Accreditation Council for Graduate Medical Education (ACGME) approval on October 22, 1991 was based upon the program's conduct in the subjected cost reporting period. Thus, the related FTE residents should be included in the Provider's GME and IME reimbursement determination for FYE June 30, 1991. The Board, however, determined that the disallowed residents should be reimbursed through Worksheet D-2 in accordance with 42 C.F.R. §405.523. Accordingly, the Board remanded this issue to the Intermediary with instructions to the Provider to complete Worksheet D-2 of its cost report and any other required or related forms and furnish the Intermediary with all documentation needed to support its claim.

With regard to Dr. R. Lakshman, the Board disagreed with the Intermediary's determination and held that the Provider was entitled to .16 of an FTE for GME purposes. The Board agreed with the Intermediary's determination that the Provider's original .33 FTE count should be reduced by 50 percent, because the resident was not trained in an initial residency

period. However, the Board disagreed with the Intermediary's determination to disallow the remaining .16 because the resident's resume showed him training at Loyola University Medical Center during the fiscal period in dispute instead of at the Provider's facility. The Provider's rotation schedule showed that Dr. Lakshman was at the Provider's facility for 120 days from November until April. Thus, the Board concluded that the Provider was entitled to .16 of an FTE for that resident for the GME count.

Concerning Dr. H. Abusharif, the Board upheld the Intermediary's adjustment disallowing an FTE for GME purposes because the Provider's rotation schedule showed that Dr. H. Abusharif was training at another facility, Christ Hospital, and not at the Provider's facility during the 1990-1991 residency year. In addition, the Board disagreed with the Intermediary's determination regarding Dr. Soltes and held that the Provider should be allowed an FTE for GME purposes because Dr. Soltes had passed the medical examination and the English test for the ECFMG.[4]

With regard to Drs. Wong and Myles, the Board disagreed with the Intermediary's determination to disallow 1.0 FTE each for IME purposes because the Provider could not document that on September 4, 1990, the day for counting residents for IME that the residents did not work in a non-allowable area of the hospital. The Board questioned the Intermediary's issue with the location of these residents on September 4, 1990. The record showed that these residents participated in a maternal/fetal medicine program and testimony elicited at the hearing demonstrated that these residents would not have worked in either of the Provider's non-allowable areas, i.e., psychiatry unit or rehabilitation unit.

The Board also disagreed with the Intermediary's disallowance 1.0 FTE each for IME for Drs. Kaskel and Abrams. The Board held that the Intermediary's denial was based upon speculation. The best evidence available were the rotation schedules, which showed that the residents in question were at the Provider's facility on the IME count date. Furthermore the letter presented from the director of the allergy/immunology fellowship program stated that residents participating in the program spent 70 percent of their time performing inpatient services, 20 percent performing outpatient services, and 10 percent in conferences. Accordingly the Board determined that the Provider was entitled to 1.0 FTE each for IME for Drs. Kaskel and Abrams.

Finally, the Board disagreed with the Intermediary's disallowance of 1.0 FTE for IME associated with Dr. Muhsin. The Board determined that the Intermediary's denial was based upon speculation as opposed to substantive evidence. The Board relied on the Provider's rotation schedules and testimony elicited at the hearing. The record showed that the Johnson R. Newman Rehabilitation Clinic consisted of an acute care facility in September 1990 and, thus, the FTE should be counted.

[4] Provider's Exhibit P-38. A letter from the ECFMG to Dr. Soltes dated January 6, 1984.

ISSUE NO. 3

Issue No. 3 is whether the Intermediary properly disallowed expenses relating to the "Inn at University Village" rather than re-classifying the expenses as investment losses to be offset against investment income.

A majority of the Board held that the Provider did not use borrowed funds to build the Inn, but instead used funds generated from patient care activities. Therefore, the Inn was an investment, and the operating loss it incurred must be offset against the Provider's investment income.

One member of the Board dissented holding that the Intermediary's adjustment should be affirmed. The dissenting Board member determined that operation of the Inn was not related to patient care, and that funds were borrowed for the Inn's construction. Furthermore, even if the construction of the Inn was financed from funds generated from patient care activities, the record showed that the Provider had enough available funds in its funded depreciation account to purchase the capital assets. The Provider was in effect reimbursing itself for the Inn construction costs from the proceeds of the Illinois Educational Facilities Authority (IEFA) loan. The IEFA loan was, therefore, unnecessary and any related interest expense unallowable.

SUMMARY OF COMMENTS

ISSUE NO. 1

CMM submitted comments requesting that the Administrator reverse the Board's decision. Specifically, CMM argued that the Provider did not qualify for "hold harmless" payments articulated in PM A-99-62. The Provider did not appeal the specific issue of GA days to the Board before October 15, 1999. PM A-99-62 was not intended to provide an opportunity for hospitals to qualify for the "hold harmless" provision by adding the issue to an existing appeal once the criteria for being eligible for the "hold harmless" payments became known.

CMM also disagreed with the Board's contention that the Provider qualified for the "hold harmless" provision because the Provider had previously appealed the exclusion of GA days in 1989 and 1990 cost reporting periods. (PRRB Case Nos. 92-1678 and 92-1717). CMM noted that the Provider had no open cost reports for these periods. These periods had been administratively resolved prior to October 15, 1999, without the inclusion of GA days. Therefore, the Provider did not expect to receive payment reflecting the inclusion of GA days, and would not have made budgeting decision based on a belief that it was entitled to such payments.

The Intermediary commented requesting that the Administrator reverse the Board's decision. Relying on the holding in St. Joseph's Hospital, 2004-D32, the Intermediary argued that the Provider did not qualify for the "hold harmless" provision because the Provider did not appeal the issue of GA day in its original appeal. The addition of GA days was added only after reading PM A-99-62. Furthermore the abandonment of the claim for GA days in prior periods evidences the lack of an institutional belief that those GA days should be included in the DSH.

The Provider commented requesting that the Administrator affirm the Board's decision. The Provider argued that it satisfied the "hold harmless" provision of PM A-99-62 in three (3) respects. First, with the filing of a jurisdictionally proper appeal to the Board on the issue of the exclusion of GA days from the Medicare DSH formula on April 1, 1998, well before October 15, 1999. Next, the Provider argued that its prior history of appealing the exclusion of GA days in both its 1989 and 1990 appeals satisfied the "hold harmless" provisions of PM A-99-62. Finally, the Provider argued that it satisfied the "hold harmless" provision of PM A-99-62 based on the Board's independent analysis of the case. The Board found that the Provider added the issue of GA days after October 1999, (a point which the Provider does not concede) but found this to satisfy PM A-99-62 because the Provider had also appealed the issue in other cost reporting periods.

ISSUE NO. 2

CMM commented requesting that the Administrator reverse the Board's determination with respect to the neuroradiology program because the Provider's neuroradiology program was not an approved program recognized by an approving body until October 22, 1991.

With regard to the Board's ruling on several resident-specific issues, CMM agreed with the Board's determination to allow 0.16 of an FTE for GME for Dr. Lakshman. CMM agreed that the Provider's rotation schedule was more appropriate to use than Dr. Lakshman's resume. CMM also agreed with the Board's disallowance of 1.0 FTE associated with Dr. Abusharif because the rotation schedule showed Dr. Abusharif was training at Christ Hospital during the 1990-1991 residency year instead of the Provider's facility. CMM disagreed with the Board's determination that the Provider should be awarded 1.0 FTE for GME purposes for Dr. Soltes. CMM argued that absent a valid ECFMG certificate or passing the FMGEMS examination, Dr. Soltes, a foreign medical graduate (FMG), could not be counted in the GME count for Medicare payment purposes.

CMM disagreed with the Board's determination and requested that the Administrator reverse the Board's decision allowing 1.0 FTE each for IME purposes for Drs. Wong and Myles. CMM argued that the 1.0 FTE for each resident for IME should be disallowed because the Provider could not document that these residents did not work in a non-allowable area of the hospital on the day for counting residents for IME. CMM agreed with the Board's determination to allow 1.0 FTE each for IME for Drs. Kaskel and Abrams. Finally, CMM

disagreed with the Board determination to allow 1.0 FTE for IME purposes for Dr. Muhsin The Provider failed to provide documentation demonstrating that Dr. Muhsin did not rotate through the Provider's subprovider unit located in the Johnson R. Newman Rehabilitation Clinic, on September 4, 1990 the day for counting residents for IME.

The Provider commented requesting that the Administrator reverse the Board's finding that 12 of the Provider's 13 fellowship programs were not "approved programs." Relying on language found in the September 1989 preamble to the GME regulation, the Provider argued that the emerging development of fellowship programs in 1991 should be considered when determining if the Provider's fellowship programs were "approved programs."[5] In addition, for those interns and residents that were not included in the Provider's GME and IME count, the Provider argued that they should be paid pursuant to 42 C.F.R. §405.522, *Interns' and residents' services not in approved teaching programs.*

Finally, concerning the resident-specific issues, the Provider urged the Administrator to affirm all but one of the Board's findings on the individual resident documentation disputes. The Provider argued that Dr. Abusharif participated in a special joint program offered by both Christ Hospital and the Provider. The Provider further argued that, because of this arrangement, Abusharif did not participate on the same rotation schedule, and although he provided some services at Christ, Abusharif spent most of his time at the Provider and therefore, should be counted for GME purposes.

ISSUE NO. 3

CMM commented requesting that the Administrator reverse the Board's decision. CMM stated that the Intermediary correctly applied Medicare policy in disallowing the Inn's costs as unrelated to patient care. CMM argued that according to PRM §226.4(C), available funded depreciation must be withdrawn and used before resorting to borrowing for the acquisition of depreciable assets or other capital purposes, except that when available funded depreciation is insufficient to cover the total cost of a major construction project and borrowing is necessary because there was insufficient funds available in the funded depreciation account to purchase the capital assets. In this case, the IEFA loan was unnecessary and any related interest expense unallowable. Therefore, the Intermediary correctly applied Medicare policy in disallowing the Inn's costs as unrelated to patient care.

The Provider commented requesting that the Administrator affirm the Board's decision. The Provider argued that the expenditures for operating the Inn should be considered an investment loss to be aggregated with the Provider's other investment income and losses and offset against the Provider's interest expense. The Provider also argued that the evidence showed that the proceeds from the IEFA loan were not used to fund the Inn and the bond

[5] 54 Fed. Reg. 40286, 40295, Sept. 29, 1989.

covenants within the loan legally prevent the Provider from using the proceeds for the Inn. Therefore, the Board's decision regarding this matter should be affirmed.

The Intermediary commented requesting that the Administrator reverse the Board's determination. The Intermediary argued that the Provider borrowed the funds to go into the hotel business and the lack of success for this venture should not be shared by the Medicare Program.

DISCUSSION

The entire record, which was furnished by the Board, has been examined, including all correspondence, position papers, and exhibits. The Administrator has reviewed the Board's decision. All comments received timely are included in the record and have been considered.

ISSUE NO. 1

Relevant to the issue involved in this case, two Federal programs, Medicaid and Medicare involve the provision of health care services to certain distinct patient populations. The Medicaid program is a cooperative Federal-State program that provides health care to indigent persons who are aged, blind or disabled or members of families with dependent children.[6] The program is jointly financed by the Federal and State governments and administered by the States according to Federal guidelines. Medicaid, under Title XIX of the Social Security Act (Act), establishes two eligibility groups for medical assistance: categorically needy and medically needy. Participating States are required to provide Medicaid coverage to the categorically needy.[7] The "categorically needy" are persons eligible for cash assistance under two Federal programs: Aid to Families with Dependent Children (AFDC) [42 USC 601 et. seq.] and Supplemental Security Income or SSI [42 USC 1381, et. seq.]. Participating States may elect to provide for payments of medical services to those aged blind or disabled individuals known as "medically needy" whose incomes or resources, while exceeding the financial eligibility requirements for the categorically needy (such as an SSI recipient) are insufficient to pay for necessary medical care.[8]

In order to participate in the Medicaid program, a State must submit a plan for medical assistance to CMS for approval. The State plan must specify, inter alia, the categories of individuals who will receive medical assistance under the plan and the specific kinds of medical care and services that will be covered.[9] If the State plan is approved by CMS, the State is thereafter eligible to receive

[6] Section 1901 of the Social Security Act (Act) (Pub. Law 89-97.)
[7] Section 1902(a) (10) of the Act.
[8] Section 1902(a) (1) (C) (i) of the Act.
[9] Id. §1902 et. seq. of the Act.

matching payments from the Federal government based on a specified percentage (the Federal medical assistance percentage) of the amounts expended as medical assistance under the State plan.

Within broad Federal rules, States enjoy a measure of flexibility to determine "eligible groups, types and range of services, payment levels for services, and administrative and operating procedures."[10] In particular, the Medicaid statute sets forth a number of requirements, including income and resource limitations that apply to individuals who wish to receive medical assistance under the State plan. Individuals who do not meet the applicable requirements are not eligible for medical assistance under the State plan.

Section 1901 of the Social Security Act sets forth that appropriations under that title are "[f]or the purpose of enabling each State, as far as practicable under the conditions in such State, to furnish medical assistance on behalf of families with dependent children and of aged, blind or disabled individuals whose incomes and resources are insufficient to meet the costs of necessary medical services…." Section 1902 sets forth the criteria for state plan approval. As part of a State plan, Section 1902(a)(13)(A)(iv) requires that a State plan provide for a public process for determination of payment under the plan for, inter alia, hospital services which in the case of hospitals, take into account (in a manner consistent with section 1923) the situation of hospitals which serve a disproportionate number of low-income patients with special needs. Section 1905 defines the term "medical assistance" within the context of the payment of part or all of the costs of certain specified care and medical services and the identification of certain individuals for whom payment maybe made.

Section 1923 of the Act implements the requirements that a State plan under Title XIX provide for an adjustment in payment for inpatient hospital services furnished by a disproportionate share hospital. A hospital maybe deemed to be a Medicaid disproportionate share hospital pursuant to Section 1923(b)(1)(A), which addresses a hospital's Medicaid inpatient utilization rate, or under paragraph (B), which addresses a hospital's low-income utilization rate. The latter criteria relies, inter alia, on the total amount of the hospital's charges for inpatient services which are attributable to charity care.

While Title XIX implemented medical assistance pursuant to a cooperative program with the States for certain low-income individuals, the Social Security Amendments of 1965[11] established title XVIII of the Act, which authorized the establishment of the Medicare program to pay part of the costs of the health care services furnished to entitled beneficiaries. The Medicare program primarily provides medical services to aged and disabled persons and consists of two Parts: Part A, which provides reimbursement for inpatient hospital and related post-hospital, home health, and

[10] Id.
[11] Pub. Law No. 89-97.

hospice care,[12] and Part B, which is supplemental voluntary insurance program for hospital outpatient services, physician services and other services not covered under Part A.[13] At its inception in 1965, Medicare paid for the reasonable cost of furnishing covered services to beneficiaries.[14] However, concerned with increasing costs, Congress enacted Title VI of the Social Security Amendments of 1983.[15] This provision added §1886(d) of the Act and established the inpatient prospective payment system (IPPS) for reimbursement of inpatient hospital operating costs for all items and services provided to Medicare beneficiaries, other than physician's services, associated with each discharge. The purpose of IPPS was to reform the financial incentives hospitals face, promoting efficiency by rewarding cost effective hospital practices.[16]

These amendments changed the method of payment for inpatient hospital services for most hospitals under Medicare. Under IPPS, hospitals and other health care providers are reimburse their inpatient operating costs on the basis of prospectively determined national and regional rates for each discharge rather than reasonable operating costs. Thus, hospitals are paid based on a predetermined amount depending on the patient's diagnosis at the time of discharge. Hospitals are paid a fixed amount for each patient based on one of almost 500 diagnosis related groups (DRG) subject to certain payment adjustments.

Concerned with possible payment inequities for IPPS hospitals that treat a disproportionate share of low-income patients, pursuant to Section 1886(d) (5) (F) (i) of the Act, Congress directed the Secretary to provide, for discharges occurring after May 1, 1986, "for hospitals serving a significantly disproportionate number of low-income patients…."[17]

There are two methods to determine eligibility for a Medicare DSH adjustment: the "proxy method" and the "Pickle method."[18] To be eligible for the DSH payment under the proxy method, an IPPS hospital must meet certain criteria concerning, inter alia, its disproportionate patient percentage. Relevant to this case, with respect to the proxy method, Section 1886 (d)(5)(F)(vi) of the Act states that the terms "disproportionate patient percentage" means the sum of two fractions which is expressed as a percentage for a hospital's cost reporting period. The fractions are often referred to as the "Medicare low-income proxy" and the Medicaid low-income proxy", respectively, and are defined as follows:

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[12] Section 1811-1821 of the Act.
[13] Section 1831-1848(j) of the Act.
[14] Under Medicare, Part A services are furnished by providers of services.
[15] Pub. Law No. 98.21.
[16] H.R. Rep. No. 25, 98th Cong., 1st Sess. 132 (1983).
[17] Section 9105 of the Consolidated Omnibus Budget Reconciliation Act of 1985 (Pub. L. No. 99-272). See also 51 Fed. Reg. 16772, 16773-16776 (1986).
[18] The Pickle method is set forth at section 1886(d) (F) (i) (II) of the Act.

> (I) the 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 patients day for such fiscal year which were made up of patients who (for such days) were entitled to benefits under Part A of this title.
>
> (II) the fraction (expressed as a percentage), the numerator of which is the number of the hospital's patients days for such period which consists 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 athe denominator of which is the total number of the hospital patients days for such period. (Emphasis added.)

CMS implemented the statutory provisions at 42 CFR 412.106. The first computation, the "Medicare proxy" or "Clause I" is set forth at 42 CFR 412.106(b)(2). Relevant to this case, the second computation, the "Medicaid-low income proxy", or "Clause II", is set forth at 42 CFR 412.106(b) (4) (1991) and provides that:

> *Second computation.* The fiscal intermediary determines, for the hospital's cost reporting period, the number of patient days furnished to patients entitled to Medicaid but not to Medicare Part A, and divides that number by the total number of patient days in the same period..[19]

In conjunction with this revision, CMS issued a Memorandum dated June 12, 1997, which explained the counting of patient days under the Medicaid fraction, stating that:

> We note that individuals who are eligible for payments under a demonstration project, but would not be eligible under the provisions of the underlying State plan, are not included in this definition. Demonstration projects often involve waivers of State plan provisions; individuals eligible only by virtue of those waivers are not eligible under the State plan itself. Thus, they would not meet the statutory definition of Medicaid days….

[19] CMS revised 42 C.F.R. 412.106(b)(4) to conform to HCFA Ruling 97-2, which was issued in light of Federal Circuit Court decisions disagreeing with CMS' interpretation of a certain portion of §1886(d)(5)(vi)(II) of the Act. Revised 42 C.F.R. §412.106(b) applies to cost reporting periods beginning on or after October 1, 1998. 63 Fed. Reg. 40954, 400985 (1998).

In particular, concerning individuals eligible for payment under a demonstration project, CMS explained that:

> [S]ome States have a demonstration project which includes expanded eligibility populations who would not be eligible under a State plan under title XIX, or a State waiver which includes people who are not and would not have been Medicaid Title XIX beneficiaries. Inpatient hospital days for these non- Medicaid individuals would not be properly included in the calculation of Medicaid days. State record should distinguish between individuals eligible under the State plan and individuals who are only eligible under a demonstration project or waiver.

However, while CMS assumed that State record would distinguish between individuals eligible under the State plan and those individuals who were eligible under a demonstration project or waiver, problems arose. In 1999, CMS observed certain practices and policies regarding Medicare DSH payment reflecting confusion regarding the counting of certain days for purposes of the DSH calculation. CMS determined that certain hospitals and intermediaries relied on Medicaid day data obtained from State Medicaid agencies to compute Medicare DSH payments and that some of those agencies commingled the types of otherwise ineligible days with Medicaid Title XIX days in the data transmitted to hospitals and/or intermediaries.

In order to again state the definition of eligible Medicaid days and to communicate a hold harmless position for cost reporting periods beginning before January 1, 2000, for certain providers, CMS issued Program Memorandum (PM) A-99-62, dated December 1, 1999. This program memorandum again explained that State-only and waiver days were not to be counted in the Medicaid proxy. With respect to included days, the PM A-99-62 stated that the hospital must determine whether the patient was eligible for Medicaid under a State plan approved under Title XIX on the day of service. If the patient were so eligible, the day counts in the Medicare disproportionate share adjustment calculation. Thus, for a day to be counted, the patient must be eligible on that day for medical assistance benefits under an approved Title XIX State plan.

Consistent with this definition of days to be included, the PM-A-99-62 stated regarding the exclusion of days, that:

> Many States operate programs that include both State-only and Federal-State eligibility groups in an integrated program…. These beneficiaries, however, are not eligible for Medicaid under a State plan approved under Title XIX, and therefore, days utilized by these beneficiaries do not count in the Medicare disproportionate share adjustment calculation. If a hospital is unable to distinguish between Medicaid beneficiaries and other medical assistance beneficiaries, then it must contact the State for assistance in doing so.

…

> Regardless of the type of allowable Medicaid day, the hospital bears the burden of proof and must verify with the State that the patient was eligible under one of the allowable categories during each day of the patient's stay. The hospital is responsible for and must provide adequate document to substantiate the number of Medicaid days claimed.

In addition, for those providers that were genuinely confused or held a genuine belief that, for example, certain "State-only" days and/or "waiver days" were to be included in the DSH calculation, CMS announced a hold harmless policy for cost reporting periods beginning before January 1, 2000. Pertinent to this case, CMS instructed intermediaries, pursuant to the PM A-99-62, to apply the hold harmless policy under certain limited circumstances. Regarding hospitals that did not receive payments reflecting the erroneous inclusion of days at issue, CMS stated that:

> If, for cost reporting periods beginning before January 1, 2000, a hospital that did not receive payments reflecting the erroneous inclusion of otherwise ineligible days filed a jurisdictionally proper appeal to the PRRB on the issue of the exclusion of these types of days from the Medicare DSH formula before October 15, 1999, reopen the cost report at issue and revise the Medicare DSH payment to reflect the inclusion of these types of days as Medicaid days. The actual number of these types of days that you use in this revision must be properly supported by adequate documentation provided by the hospital. Do not reopen a cost report and revise the Medicare DSH payment to reflect the inclusion of these types of days as Medicaid days if, on or after October 15, 1999, a hospital added the issue of the exclusion of these types of days to a jurisdictionally proper appeal already pending before PRRB on other Medicare DSH issues or other unrelated issues.

Subsequent to the issuance of PM A-99-62, a series of questions and answers was issued by CMS. Questions 12 through 15 address various aspects of the "hold harmless" provision. Of particular relevance is Question 15 which states that:

> How are intermediaries to handle a situation where the hospital filed a jurisdictionally proper general DSH appeal without specifically addressing the ineligible days (i.e., general assistance or other State-only health programs, charity care, Medicaid DSH, and / or ineligible waiver or demonstration population days)?
>
> A. PM A-99-62 specifies on page 3 and page 4 that the hold harmless provision applies only to jurisdictionally proper appeals on the issue of the exclusion of these types of days from the Medicare DSH formula.

> This reinforces the statement in the last sentence of the first paragraph on page 3 of the PM which states "… this decision is not intended to hold hospitals harmless for any other aspect of the calculation of Medicare DSH payments…" Therefore, the intermediaries should not apply the hold harmless provisions in situations of general Medicare DSH appeals unless the hospital furnishes proof that the appeal includes the issue of these types of ineligible days. Even if the appeal is somewhat more specific and address Medicaid days, the intermediary should make every effort to determine whether the general assistance of other State-only health program, charity care, Medicaid DSH, and/ or ineligible waiver or demonstration days are at issue…..

In this case, the Provider argued that it satisfied the "hold harmless" provision of PM A-99-62. First, it claimed that it met with the filing of a jurisdictionally proper appeal to the Board on the issue of the exclusion of GA days from the Medicare DSH formula on April 1, 1998, well before October 15, 1999. Next, the Provider argued that its prior history of appealing the exclusion of GA days in both its 1989 and 1990 appeals satisfied the "hold harmless" provisions of PM A-99-62. Finally, the Provider argued that it satisfied the "hold harmless" provision of PM A-99-62 based on the Board's independent analysis of the case. The Board found that the Provider added the issue of GA days after October 1999, (a point which the Provider did not concede). The Board also held that the Provider failed to meet the requirements of HFCA Ruling 97-2 dated February 27, 1997, because the Provider did not challenge the exclusion of GA days in the fiscal period in dispute. However, the Board determined that the Provider qualified for the "hold harmless" provision of PM A-99-62 because the Provider had appealed the exclusion of GA days in 1989 and 1990 cost reporting periods. (PRRB Case Nos. 92-1678 and 92-1717). The Board concluded that the qualifying factor for the "hold harmless" provision was a history of appealing the exclusion of GA days, whether or not payment was made for those days.

Applying the relevant law and program policy to the foregoing facts, the Administrator finds that the Provider does not meet the requirements of the "hold harmless" provision of PM A-99-62. The PM A-99-62 advised Intermediaries' to "hold harmless" from those providers that had been improperly allowed to include general assistance or other State-only health programs, charity care, Medicaid DSH, and/or ineligible waiver or demonstration population days" in their calculation of the Medicaid fraction. In addition, PM A-99-62 also advised Intermediaries to "hold harmless" those providers that had filed a jurisdictionally proper appeal before October 15, 1999, on the precise issue of general assistance or other State-only health programs, charity care, Medicaid DSH, and/or ineligible waiver or demonstration population days" even if the provider had not been erroneously reimbursed for the inclusion of otherwise ineligible days in their cost report.

In this case, the record shows that the Provider, by letter dated March 31, 1994, filed a notice of appeal to the Board. The Provider made no reference of appealing the GA days. The record also shows that on April 1, 1998, the Provider filed it preliminary position paper and there was no mention of "these types of days" (i.e., GA days) in the Provider's DSH argument. The Provider's preliminary position paper only challenged the exclusion of "all inpatient hospital days" as directed by HCFA Ruling No. 97-2 dated February 27, 1997.[20] Only after the issuance of PM A-99-62, did the Provider add GA days to its existing appeal through the submission of a revised final brief filed with the Board on May 21, 2002. Thus, the Administrator finds no statement by the Provider before October 15, 1999, that it was appealing GA days.

The Administrator also disagrees with the Board's determination that by adding the GA days to its existing appeal after October 15, 1999, the Provider qualified for the "hold harmless" provisions of PM A-99-62. The Administrator finds that PM A-99-62, instructed Intermediaries "not to reopen a cost report and revise the Medicare DSH payment to reflect the inclusion of these types of days as Medicaid days, if, on or after October 15, 1999, a hospital added the issue of the exclusion of these types of days to a jurisdictionally proper appeal already pending before the Board on other Medicare DSH issues or other unrelated issues." The Administrator agrees with the District Court in United Hospital, which stated:

> The Program Memo does not extend to all hospitals that had filed a jurisdictionally proper appeal before October 15, 1999, and that raised the issue of the exclusion of general assistance days. Rather, on it face, the Program Memo extends only to hospitals that had filed a jurisdictionally proper appeal on the issue of the exclusion of general assistance days before October 15, 1999. In other words, on it face, the Program Memo requires that, that, in order to be eligible for relief, a hospital must have raised the precise issue of exclusion of general assistance days before October, 15, 1999.

Finally, the Administrator disagrees with the Board's determination that the Provider qualified for the "hold harmless" provision of PM A-99-62 because the Provider had previously appealed the exclusion of GA days in 1989 and 1990 cost reporting periods. The Administrator notes that the appeals of the 1989 and 1990 cost reporting periods were administratively resolved prior to October 15, 1999, without the inclusion of GA days. The Intermediary cannot continue to pay the Medicare DSH adjustment reflecting the inclusion of GA days to the Provider, one of the conditions for application of the "hold harmless" provision, as the Intermediary had not made such incorrect payments in the past. As the Provider had not received payment in the past reflecting the inclusion of GA days, it would not have made budgeting decision based on a belief that it would continue to be entitled to

[20] Provider's Position Paper at p.. 14, received April 1, 1998.

such payments. Thus, the Provider does not qualify for the "hold harmless" provisions of PM A-99-62 and the Intermediary's DSH calculation of the Provider's DSH payment was proper.

ISSUE NO. 2

Through legislation enacted in 1986, Congress established a new payment policy for direct medical education costs at §1886(h) of the Act.[21] Section 1886(h)(2) of the Act, states that "[t]he Secretary shall determine, for each hospital with an approved medical residency training program, an approved FTE resident amount for each cost reporting period beginning on or after July 1, 1985."[22] Section 1886(h)(5)(A) of the Act, defines "approved medical residency training program" as meaning "a residency or other postgraduate medical training program participation in which may be counted toward certification in a specialty or sub-specialty and includes formal postgraduate training programs in geriatric medicine approved by the Secretary."[23] Section 188(h)(4)(A) of the Act, directs the Secretary to "establish rules consistent with this paragraph for the computation of the number of full-time equivalent residents in an approved medical residency training program."

To implement this new policy for purposes of determining the total number of FTE residents, the Secretary promulgated regulations at 42 C.F.R. §413.86 et seq. Relevant to this case, 42 C.F.R. §413.86(b)(1990) provides, in pertinent part, that an *approved medical residency program* means a program that meets one of the following criteria:

> (1) Is approved by one of the national organizations listed in §405.522(a) of this chapter.
> (2) May count towards certification of the participant in a specialty or subspecialty listed in the Directory of Residency Training Programs published by the American Medical Association.
> (3) Is approved by the Accreditation Council for Graduate Medical Education (ACGME) as a fellowship program in geriatric medicine….

42 C.F.R. §405.522(a) (1990) lists the national approving organizations as states that:

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[21] Consolidated Omnibus Budget Reconciliation Act of 1985, Pub. L. No. 99-272, §9202 (April 7, 1986), as amended by the Omnibus Budget Reconciliation Act of 1986, Pub. L. 99-509.

[22] Section 1886(h) (2) of the Act. The revised payment method applies to all hospitals regardless of their status under the IPPS. 54 Fed. Reg. at 40297-8.

[23] 42 CFR 413.86(a) and (b).

> Title XVIII of the Act gives recognition to hospital teaching programs which are duly approved in their respective fields by the Accreditation Council for Graduate Medical Education of the American Medical Association, by the Committee on Hospitals of the Bureau of Professional Education of the American Osteopathic Association, by the Council on Dental Education of the American Dental Association, or, for provider cost reporting periods beginning after December 31, 1972, by the Council of Podiatry Association.

Finally, 42 C.F.R. §413.86 defines a foreign medical graduate (FMG) as:

> A resident who is not a graduate of a medical, osteopathy, dental, or podiatry school, respectively, accredited or approved as meeting the standards necessary for accreditation by one of the following organizations:
>
> (1) The Liaison Committee on Medical Education of the American Medical Association.
> (2) The American Osteopathic Association.
> (3) The Commission on Dental Accreditation.
> (4) The Council on Podiatric Medical Education.

The regulation at 42 C.F.R. 413.86(h) states that:

> The weighting factor for a foreign medical graduate is determined under the provisions of paragraph (g) of this section if the foreign medical graduate—
>
> > (i) Has passed FMGEMS; or
> > (ii) Before July 1, 1986, received certification from, or passed an examination of, the Educational Committee for Foreign Medical Graduate.

In addition, as provided under the regulation at 42 CFR 412.105, formerly 42 CFR 412.118 (1990), under IPPS, an additional payment for indirect medical education (IME) costs is made generally based on a ratio of FTE residents to number of beds. Paragraph (f)(1990) provides that regarding the count of residents for cost reporting periods beginning before July 1, 1991, the following criteria must be met:

> 1) The residents must be enrolled in a teaching program approved under 413.85[24] of this chapter (excluding those employed by the hospital, but furnishing services at another site.)
> 2) The hospital must submit an annual report to its fiscal intermediary. The report must include the following information. (i) A listing by specialty of all residents assigned to the hospital and providing services to the hospital on September 1 of that year…. (ii) The social security number of each resident. (iii) The hospital unit or department to which each resident is assigned on the day of the count
> 3) No resident will be counted as more than one full time employee on the date counted….
> 4) Fiscal intermediaries must verify the correct count of residents and may review the hospitals entire cost reporting period.
> 5) Residents who are assigned to a setting other than the inpatient or outpatient department of the hospital (such as freestanding family practice center or an excluded hospital unit) on that day that the count of interns and residents … is made are not counted as fulltime equivalents. Only the percentage of time that these residents spend in the portion of the hospital subject to the prospective payment system or in the outpatient department of the hospital on the day the count is made is used to determine the indirect medical education adjustment.

The regulation at 42 CFR 413.85(b) (1990) (formerly 42 CFR 405.421) states that:

> Definition—Approved educational activities. Approved educational activities means the formally organized or planned programs of study usually engaged in by providers in order to enhance the quality of care in an institution. These activities must be licensed if required by State law. If licensing is not required, the institution must receive approval from the recognized national professional organization for the particular activity.

In this case, the Intermediary disallowed a number of full-time equivalent or FTEs claimed by the Provider for purposes of both the GME and IME payment because the residents participated in a medical education fellowship program that was not approved pursuant to 42 C.F.R. §413.86(b). The Provider argued that the emerging development of fellowship programs in 1991, the cost year at issue, should be considered when determining if the Provider's fellowship programs were "approved programs." The Board held that the Intermediary correctly disallowed several FTEs associated with 12 of the 13 fellowship program that had not been approved by a recognized approving organization at the time of the

[24] 42 CFR 413.85(a)(2) (1990) explains that for cost reporting periods beginning on or after July 1, 1985, payment to hospitals for approved residency programs in medicine, osteopathy, dentistry and podiatry is determined as provided in 413.86.

subject cost reporting period. The Board however, made an exception to the disallowance for those FTEs associated with the Provider's neuroradiology. The Board concluded that these FTEs should be part of the Provider's total FTE count because the ACGME approval on October 22, 1991 was based upon the program's conduct in the subject cost reporting period.

Applying the relevant law and program policy to the foregoing facts, the Administrator agrees with the Board's determination that the FTEs disallowed by the Intermediary was proper because 12 of the Provider's fellowship program had not been approved by a recognized approving organization at the time of the subject cost reporting period.

The Administrator also disagrees with the Board's determination to include the FTEs associated with the Provider's neuroradiology program. The Administrator finds that 42 C.F.R. §413.86(b) defines an "approved medical residency program," in general, as one that is either approved by a national accrediting organization, or is recognized by the national board as counting towards certification in a particular specialty. The record shows that in a letter to the Intermediary, dated June 7, 2001,[25] CMS contacted the ACGME to ascertain whether the neuroradiology program at the Provider's was accredited during the July 1990—June 1991 program year. CMS was informed that the Residency Review Committee (RRC) for Radiology had initially reviewed the Provider's program in March of 1991, but did not grant accreditation due to lack of adequate information. The program was later reviewed in September of 1991 and it was granted accreditation by letter dated October 22, 1991.[26] In this case, the cost reporting period under appeal is for the FYE June 30, 1991, which coincides with the July 1, 1990—June 30, 1991 academic year. The accreditation was not granted until after that academic year. Accordingly, the Administrator finds that the residents at the Provider training in the neuroradiology program during the 1990-1991 academic year were not training in a program approved by the ACGME.

The Administrator notes that as a result of the Provider's neuroradiology program not being accredited by ACGME during the year in question, CMS then contacted the American Board of Radiology to establish whether the residency training occurring in the 1990-1991 year was counted towards board certification in neuroradiology. An American Board representative explained to CMS that in the past 20 to 30 years, hospitals have independently operated fellowship programs without oversight from the ACGME or the American Board of Radiology in subspecialties such as neuroradiology, following a diagnostic radiology residency. It was not until the early 1990s, that the American Board announced that it would begin to offer additional board certification in these subspecialties. Subsequent to that announcement, the ACGME began to formally review and approve these fellowships.

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[25] Intermediary's Exhibit I-8.

[26] Provider's Exhibit P-24. ACGME accreditation approval letter dated October 22, 1991 (Neuroradiology Fellowship Program).

Since the American Board of Radiology did not actually recognize a neuroradiology program until the program was accredited by the ACGME, the neuroradiology fellowship program at the Provider's during the 1990-1991 academic year did not count toward board certification. Therefore, the Administrator disagrees with the Board's determination and finds that the Intermediary's disallowance of the FTEs in the neuroradiology program was proper. Accordingly the decision of the Board addressing the neuroradiology department FTEs is reversed.

Concerning specific resident issues for GME and IME purposes, the Administrator agrees with the Board's determination to allow 0.16 of an FTE for GME purposes for Dr. Lakshman. The Provider's rotation schedule, which supports such a finding, is a more appropriate document to use than Dr. Lakshman's resume. The Administrator also agrees with the Board's disallowance of 1.0 FTE associated with Dr. Abusharif because the Provider's rotation schedule showed Dr. Abusharif was training at Christ Hospital during the 1990-1991 academic year instead of the Provider's facility. The Administrator also agrees with the Board's determination to allow an FTE for GME purposes for Dr. Soltes because Dr. Soltes passed the medical examination and the English test of the ECFMG. The record shows a letter from ECFMG dated January 6, 1984, stating that the Dr. Soltes had passed the medical examination and the English test.

The Administrator disagrees with the Board's determination to allow 1.0 FTE each for IME for Drs. Wong and Myles. The Provider did not furnish reasonable documentation to the Intermediary identifying the location of the residents' training in the hospital on the date of the IME count on September 4, 1990. The Administrator agrees with the Board's determination to allow 1.0 FTE each for IME for Drs. Kaskel and Abrams. The best evidence available, which is the rotation schedule, shows the residents at the Provider's inpatient facility on the IME count date. Finally, the Administrator disagrees with the Board's determination to allow an FTE for Dr. Muhsin. The Provider's rotation schedule places the resident at the JRB Clinic on the IME count date. In addition, the record shows that the JRB houses a subprovider unit. Under 42 C.F.R. §412.105(f)(1)(ii), rotations through a subprovider unit, excluded from the Inpatient PPS, are not to be included in the IME count. The record shows that the Provider could not provide documentation specific enough that the resident did not rotate through the Provider's subprovider unit on the IME count date. As such, the Administrator agrees with the Intermediary's disallowance of 1.0 FTE associated with Dr. Muhsin for IME.

Finally, the Administrator notes that, in the alternative the Provider argued that for those fellowship participants not allowed, that the Provider should still be reimbursed pursuant to 42 C.F.R. §405.523, *Interns' and residents' services not in approved teaching programs*. The record shows that the Intermediary did not dispute that the costs could been orginally claimed in this matter. However, the Intermediary stated that it understood that the Provider did not have the voluminous data necessary to complete Worksheet D-2, nor has the Provider offered

proof that such documentation still exists. Thus, the Administrator finds that remand is not appropriate in this case for that determination.

ISSUE NO. 3

Section 1861(v)(1)(A) of the Social Security Act and the regulations at 42 C.F.R. §413.9 requires that reimbursement to providers be based on reasonable cost. Reasonable cost is defined as the costs actually incurred, but subject to a limitation that the costs with respect to the individuals covered by the program will not be incurred by individuals not so covered, and vice versa.

Reasonable costs include capital-related costs. Consistent with the Secretary's rulemaking authority, the Secretary promulgated 42 CFR §413.130, which lists capital-related costs that are reimbursable under Medicare. Capital-related costs under Medicare include depreciation, interest, taxes, insurance, and similar expenses (defined further in 42 CFR §413.130) for plant and fixed equipment, and for movable equipment.

Consistent with the Act and the regulations, the above principles are set forth in the Provider Reimbursement Manual (PRM), which provides guidelines and policies to implement Medicare regulations for determining the reasonable cost of provider services. Relevant to this case, the PRM at §2102.2, *Costs Related to Patient Care*, states that:

> These include all necessary and proper costs which are appropriate and helpful in developing and maintaining the operation of patient care facilities and activities. Necessary and proper costs related to patient care are usually costs which are common and accepted occurrences in the field of the provider's activity. They include personnel cost, administrative costs, cost of employee pension plans, normal standby costs, and others. Allowability of costs is subject to the regulations prescribing the treatment of specific items under the Medicare program.

The PRM at §2102.3, *Cost Not Related to Patient Care*, states that:

> Costs not related to patient care are costs which are not appropriate or necessary and proper in developing and maintaining the operation of patient care facilities and activities. Costs which are not necessary include costs which usually are not common or accepted occurrences in the field of the provider's activity.
>
> Such costs are not allowable in computing reimbursable costs….

With regard to interest, the PRM at §200 states that:

> Necessary and proper interest on both current and capital indebtedness is an allowable cost.

Section 202.1 of the PRM defines interest and states that:

> To be allowable under the Medicare program, interest must be:
> —identified in your accounting records;
> —related to the reporting period in which the costs are incurred; and
> —necessary and proper for the operation, maintenance, or acquisition of your facilities.

PRM at §202.2 defines "necessary" and states that:

> Necessary means that the interest is incurred on a loan made to satisfy your financial need and for a purpose reasonably related to patient care." For example, where funds are borrowed for purposes of investing in other than your operations, interest expense is not allowable; such a loan is not considered necessary. Likewise, when borrowed funds create excess working capital, interest expense on such borrowed funds is not an allowable cost.

Subsection B of the PRM at §202.2 states, in pertinent part that:

> Where funds are borrowed for purposes of investing in other than the provider's own patient care related activities, interest expense is not allowable. Such a loan is not considered necessary

Subsection C of the PRM §202.2 Offset By Investment Income states, in pertinent part that:

> Patient care funds should be available for the provider's patient care purposes, enabling it to avoid interest expense attributable to unnecessary borrowing. If funds generated from patient care activities are invested in nonpatient care related activities, the provider's allowable interest expense is reduced (offset) by the provider's investment income in order to determine the amount of interest expense that is necessary and therefore allowable. The investment income is only offset against allowable interest expense. See §2086.1G.
>
> Investment income for offset is the aggregate amount realized from all investments of patient care funds in nonpatient care related activities and may include interest, dividends, operating profits and losses, and gains and losses on sale or disposition of investment
> ….

> Any investment income (subject to offset) in excess of allowable interest expense is not used to offset other expenses. If the aggregate net amount realized from all investments of patient care related funds is a loss, the loss is not allowable. The net loss is not added to interest expense and it is not an allowable expense…
>
> Investment income resulting from investment of funds not generated from patient care activities is not subject to offset. In addition, if the invested in nonpatient care activities are borrowed, the interest expense is not allowable and the investment income is not subject to offset. (Emphasis added.)

In this case, the Provider accepted the Intermediary's position, that the costs incurred by the Inn were not related to patient care. However, the Provider next argued the operating loss should have been allowed as an offset to investment income. Further, the interest expense related to the IEFA loan should be allowed.

The Provider and a majority of the Board concluded that the Provider did not use borrowed funds to build the Inn but instead used funds generated from patient care activities. Therefore, the Board concluded that the Inn was an investment, and the operating loss it incurred must be offset against the Provider's investment income.

The Administrator does not agree. A review of the record shows that the Provider borrowed funds of $10 million (the IEFA loan) in and around that time of the construction of the Inn. The loan documents indicate that it was to reimburse the Provider for previously made capital expenditures. However, once these capital expenditures were identified, it is not clear that the Provider was required to account for the funds actual use. The record shows that interest from bonds were recorded on the Provider's books as associated with the Inn.[27] In addition, Arthur Andersen, the Provider's CPA discusses the capitalization of interest expense related to the construction of the Inn, in the workpapers and states that:

> AA&CO noted that the interest expense relating to the $10MM debt used for construction of the Inn at University Village was not being properly capitalized… The 10MM debt is considered to be a tax-exempt borrowing. However, the hotel built with these proceeds is not considered a qualifying asset….[28]

Furthermore, Provider's Exhibit 45 shows a construction loan interest for a loan amount of $10,000,000 associated with the Inn. These documents taken together lead the Administrator to conclude that funds were borrowed for the construction of the Inn. As stated in §202.2(C)

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[27] Provider's Exhibit 43.
[28] Intermediary's Exhibit I-21.

of the PRM above, "if the funds invested in nonpatient care activities are borrowed, the interest expense is not allowable and the investment income is not subject to offset." Accordingly the Administrator finds that the Intermediary's properly disallowed all costs associated with the Inn.

However, even assuming that the Provider did not use borrowed funds to build the Inn, but instead used funds generated from patient care activities, the Administrator finds that the interest from the IEFA loan is not allowable. The PRM at §226.4(C) states that:

> Available funded depreciation must be withdrawn and used before resorting to borrowing for the acquisition of depreciable assets or other capital purposes, except that, when available funded depreciation is insufficient to cover the total cost of a major construction project and borrowing is necessary….

The record shows that the Provider had sufficient funds available in the funded depreciation account approximate to the time the loan was made.[29] Accordingly, the IEFA loan was unnecessary and any related interest expense unallowable.

[29] Intermediary Exhibit I-27.

DECISION

ISSUE NO. 1

The decision of the Board on Issue No. 1 is reversed in accordance with the foregoing opinion.

ISSUE NO. 2

The decision of the Board on Issue No. 2 is modified in accordance with the foregoing opinion.

ISSUE NO. 3

The decision of the Board on Issue No. 3 is reversed in accordance with the foregoing opinion.

THIS CONSTITUTES THE FINAL ADMINISTRATIVE DECISION OF THE SECRETARY OF HEALTH AND HUMAN SERVICES

Date: 1/17/06

/s/
Leslie V. Norwalk, Esq.
Deputy Administrator
Centers for Medicare & Medicaid Services