PROVIDER REIMBURSEMENT REVIEW BOARD
HEARING DECISION

99-D42

PROVIDER -
Anaheim Memorial Hospital Association

Provider No. 05-0226

vs.

INTERMEDIARY -Blue Cross and Blue Shield Association/Blue Cross of California

DATE OF HEARING-
September 27, 1997

Cost Reporting Period Ended -
September 30, 1989 and 1991

CASE NO. 92-0215
94-0239

INDEX

ISSUE:

Was the Intermediary's adjustment to offset investment income earned from a related organization proper?

STATEMENT OF CASE AND PROCEDURAL HISTORY:

Anaheim Memorial Hospital Association ("Provider"/"AMHA") is a 220 bed general, short-term acute care hospital, located in Anaheim, California, operating as a voluntary non-profit community hospital. The Provider has a high ratio of critical care beds with specialties in orthopaedics, oncology and neurology.

In 1987, the community had no free standing Magnetic Resonance Imaging ("MRI") facility. The mobile units were inadequate in several respects, i.e., smaller, poor turnaround time, and not capable of handling certain areas of the body like the spine and knees which were inpatient specialties of the Provider. To accommodate the Provider's scope of patient care services and the community, the Provider initiated a joint venture to acquire and provide the necessary state-of-the-art MRI services. On April 17, 1987, the Anaheim Memorial Magnetic Resonance Imaging Center ("AMMRIC") limited partnership was formed to create a free standing facility on the Provider's premises [parking lot] via a leasing arrangement. The Provider was the sole general partner with seventy-two percent (72%) ownership by contributing $1,115,000 of facilities, equipment and other assets while the remaining twenty-eight percent (28%) was owned by other limited partners. Anaheim Health Facilities Services Corporation ("AHFSC"), a related corporation to the Provider acted as the initial limited partner which then facilitated the sale of all the limited partnership units eventually to physicians on the staff of the Provider for $285,000 in cash.[1] The limited partnership was created and physician members were solicited through a Private Placement Memorandum ("PPM").[2] The PPM at p.28 states the business objective was to generate revenues and profits for the general and limited partners. Note 8 of the PPM projected about 10% of the AMMRIC's patients would be patients of the Provider. For the cost years in dispute, the actual percentage was about 8%.

The partnership began operations of the AMMRIC during its fiscal year ended September 30, 1988. AMMRIC has its own Medicare supplier number and does not operate under the Provider's hospital license. However, AMMRIC is staffed with the Provider's employees under an employee leasing arrangement under the supervision of the Provider's Director of Radiology who reports to the Provider's administration. The Provider did not incur any additional debt to finance this venture. The only outstanding debt during the fiscal year ended ("FYE") 1989 related to bonds issued in 1985,[3] and

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[1] Provider Exhibit P-5.

[2] Provider Exhibit P-4.

[3] Provider Exhibit P-12 at 8.

for FYE 1991 debt pertained to bonds issued in 1990 to refinance the 1985 bond issue.[4] The interest paid on the 1985 bond issue was 6.0% in 1989, 7.29% on the 1990 bond issue.

The dispute arises from the Intermediary's determination that the profit earned from the AMMRIC venture was investment income; and the Intermediary made an adjustment offsetting a substantial portion of the Provider's share of the AMMRIC partnership's investment income earned against the Provider's allowable claimed interest expense in both FYE 1989 and 1991.

The Intermediary issued final Notices of Program Reimbursement ("NPR") that determined the total AMMRIC investment income to be about $438,200 and $387,800 in FYEs 1989 and 1991; and about $274,200 and $279,700 was allocated to the Provider. For FYE 1989, the Intermediary also determined that 92% of AMMRICs profits were from non-related parties because 8% was related to MRI services rendered to inpatients of the Provider. Thus, the ultimate offset was about $252,300 after an adjustment reflecting the net income realized on the MRI services rendered to the Provider's patients (8% x $274,200 = $21,900). For FYE 1991, the Intermediary did not make any modification like FYE 1989 concerning income for inpatients receiving MRI services, and made an offset adjustment for the entire portion of the Provider's AMMRIC investment income of about $279,700. The estimated Medicare reimbursement effect is about $130,000 for FY 1989 and $140,000 for FY 1991.[5]

The Provider disputed the Intermediary's NPRs relative to the investment income determinations and filed a timely hearing request to the Provider Reimbursement Review Board ("Board") and has met the jurisdiction requirements of 42 C.F.R. § 405.1801 et seq. particularly §§ 405.1835-1841. A hearing was held on September 27, 1997.

The Provider was represented by Lloyd Bookman, Esquire from the law firm of Hooper, Lundy and Bookman, Inc. The Intermediary was represented by Bernard M. Talbert, Esquire of the Blue Cross and Shield Association.

Medicare Statutory and Regulatory Background:

The Medicare law establishes that health care providers furnishing services to Medicare patients are to be reimbursed the reasonable cost ("RC") of providing such services. Title XVIII of the Social Security Act, Section 1861, codified at 42 U.S.C. § 1395x(v)(1)(A), defines RC as "the costs actually incurred, excluding therefrom any part of incurred costs found to be unnecessary in the efficient delivery of needed health services and shall be determined in accordance with regulations establishing the method or methods to be used, and the items to be included...." Id. This statutory provision also sets forth the prerequisite that Medicare shall not pay for costs incurred by non-Medicare beneficiaries, and vice-versa, i.e., Medicare prohibits cross-subsidization of costs.

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[4] Provider Exhibit P-13 at 11-12.

[5] Provider Ex P-10 for FY 89; and 5-23-96 Provider Position Paper at p.2 for FY 1991.

Congress authorized the Secretary of Health and Human Services ("Secretary") to promulgate regulations to implement the RC statutory provision. The foregoing principles are further explained in the Medicare regulations in part at 42 C.F.R. §§ 413.5, 413.9 and 413.53. The regulations at 42 C.F.R. § 413.9(b)(2) define "necessary and proper" costs as costs that are appropriate and helpful in developing and maintaining the operation of patient care facilities and activities. 42 C.F.R.§ 413.153 explains that necessary and proper interest on both current and capital indebtedness is an allowable cost assuming it was "[i]ncurred on a loan made to satisfy a financial need and for a purpose reasonably related to patient care."[6] Interest determined to be unnecessary is not allowable. Another requirement is that "necessary" interest be:

> (iii) Reduced by investment income except if such income is from gifts or grants, whether restricted or unrestricted, and that are held separate and not commingled with other funds.

42 C.F.R. § 413.153(b)(2)(iii) (Emphasis added).

The Provider Reimbursement Manual, ("HCFA Pub. 15-1") §202.2, states investment income subject to offset is limited to income derived from activities not related to patient care. The manual defines investment income for offset as:

> the aggregate net 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 or sale or disposition of investments.

HCFA Pub. 15-1 § 202.2.

The regulations also require providers to maintain "accurate cost data and other information capable of verification by qualified auditors and adequate for cost reporting under Section 1815 of the Act" which is based on the provider's "financial and statistical records" 42 C.F.R. §§ 413.20(c)(1) and 413.24(a) respectively.

PROVIDER'S STATEMENT OF ADDITIONAL FACTS:

There is a perception by both the Provider and the public that AMMRIC was part of the Provider's operations:

1. The Provider views the services furnished by AMMRIC as an integral component of providing patient care;
2. The Provider has controlled the operations of AMMRIC by staffing it with leased Provider employees who were under the supervision of the Provider's director of radiology;

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[6] 42 C.F.R. §413.153(b)(2)(ii).

3. AMMRIC was operated like an outpatient department;
4. Almost all of the physicians utilizing AMMRIC's services were on the Provider's medical staff although referrals could be made by any physician in the community.
5. Since AMMRIC was located in a free standing building in the Provider's parking lot [only forty feet from the Provider's main entrance] which was clearly identified as Anaheim Memorial Magnetic Resonance Imaging Center, the public has perceived it as part of the hospital.

PROVIDER'S CONTENTIONS:

The Provider contends that the Intermediary's adjustments offsetting its portion of the net income from AMMRIC against the Provider's otherwise allowable interest expense, were improper for three reasons:

1. Since the Provider and AMMRIC are related organizations, it is improper under the Medicare reimbursement regulations and policies to offset the income from a related organization against a Provider's allowable interest expense.
2. The Provider's share of the net income of AMMRIC was not investment income as that term was used in the Medicare reimbursement regulations. That is, the income is related to patient care rather than nonpatient care activities.
3. Assuming arguendo that there was investment income, the adjustments here were otherwise improper because the investment income offset rule was included within the regulations and manual provisions as part of the definition of a "necessary borrowing." Therefore, the purpose of the investment income offset rule is to avoid having the Medicare program reimburse for unnecessary borrowing, i.e., borrowing which result in excess funds. There was no dispute concerning any unnecessary borrowing in this case.

The Provider maintains a related organization relationship exists between it and AMMRIC. Therefore, under Medicare reimbursement regulations and policies it is improper to offset the income from a related organization against a Provider's allowable interest expense. The Provider asserts that transactions between related organizations are ignored for Medicare reimbursement purposes, and that the related organization is treated as if it were part of the provider itself. The Medicare regulations and Provider Reimbursement Manual ("HCFA Pub. 15-1") both require that related organizations be treated as if they were part of the provider for cost reimbursement purposes.[7] Since the entities are related organizations, AMMRIC must be treated as if it were an operating unit of the Provider. Thus, the income earned by AMMRIC would be income generated from operations rather than from an investment.

The Provider cites the case of Florida Medical Center v. Blue Cross and Blue Shield Assn./Blue Cross and Blue Shield Florida, PRRB Dec. No. 94-D51, June 29, 1994, CCH Medicare and Medicaid Guide ¶ 42,542, aff'd issues 1,2,4,&5 and Mod #3, HCFA Admr. Decision, Aug. 23, 1994, CCH Medicare and Medicaid Guide, ¶ 42,708. In that case, the Board held that an investment resulting

[7] 42 C.F.R. § 413.17(c)(2) and HCFA Pub. 15-1 § 1005.

from a transaction between a provider and a related organization may not be offset against the provider's interest expense.

The Provider also notes that the Medicare regulations provide that interest incurred by a provider on a loan with a related organization is not an allowable cost under 42 C.F.R. § 413.153(b)(3) and (c). The Provider also argues that its position was supported by the accounting treatment of AMMRIC on its financial statements. The Provider's financial statements were presented on a consolidated basis which includes all the activities of AMMRIC. Thus, all the assets and liabilities of AMMRIC were included on AMHA's consolidated balance sheets; and all of AMMRIC's revenue and expenses were similarly included in AMHA's statement of revenue and expenses. The 28% interest in AMMRIC owned by the limited partner investors was reflected as a minority interest on AMHA's consolidated balance sheet, and the value of this interest was reflected on AHMA's balance sheet. Similarly, the AMMRIC income allocable to the limited partner investors was included in AMHA's statement of revenue and expenses and was deducted from AMHA's income. For financial reporting purposes, AMMRIC was treated as an operating component of the Provider reflecting that the net income of AMMRIC was operating income to the Provider, not investment income.

The Provider claims its proportionate share of the net income of AMMRIC was not investment income as that term is used in the Medicare reimbursement regulations. The Provider asserts that under the Medicare regulations, investment income only pertains to income generated from nonpatient care related activities; and in this case, the activities of AMMRIC were related to patient care.

The Provider notes that the purpose of forming AMMRIC was to make available MRI services to its patients which was essential to the support of several of its specialty services. Further, the Provider was committed to providing MRI services whether or not AMMRIC was formed. The sole function of AMMRIC was to provide MRI services to patients who were predominately referred by physicians on the Provider's staff. Thus, the activities of the center were clearly related to patient care.

The Provider also argues that AMMRIC in substance was operated as if it were an outpatient department of the hospital. The MRI center was located forty feet from the Provider's main entrance, was staffed with the Provider's employees, and was managed by the Provider's administration in the same manner as any other outpatient department of the hospital. The Provider's radiologist interpreted the images produced by the MRI center. The MRI center was viewed by the public as if it were part of the hospital.

The Provider disagrees with the Intermediary's unsupportable position that services can not be related to patient care unless the services are furnished to patients while they are admitted as hospital inpatients or registered as hospital outpatients. Moreover, this position is not supported by the Medicare regulations and is inconsistent with the purpose of the investment income offset rule. The Provider states the Intermediary's witness at the hearing recognized that there was no Medicare provision which supported its narrow interpretation of the phrase "nonpatient care related" as applied to investment income.

Further, the purpose of the investment income offset rule is to avoid reimbursement of unnecessary interest expense. Here, the Provider was committed to providing MRI services, and would have expended its funds to open the MRI service directly under its own license had it not formed AMMRIC. Thus, the establishment of and the operation of the MRI center as a free standing center, rather than under the hospital's license, did not reduce the funds that would be available to the Provider or reduce the Provider's borrowing needs.

The Provider also argues that its intent should be considered in determining whether its portion of the net income of AMMRIC should be treated as investment income for Medicare purposes. The Provider's principal purpose in forming AMMRIC was to make available to its patients and its community MRI services, not to generate income. Thus, the income generated by AMMRIC's activities is income from operations and not from an investment.

The Provider states assuming arguendo that its proportionate share of AMMRIC's net income could be treated as investment income, the adjustments were improper because the intended purpose of the investment income offset rule is to avoid payment of interest on unnecessary borrowing. Since the investment income offset is included within the regulations and manual provisions as part of the definition of a "necessary borrowing," the purpose of the investment income offset rule is to avoid the Medicare program from reimbursing a provider for interest on unnecessary borrowing, i.e., borrowing which result in excess funds.

For the Provider's 1989 fiscal year, the Provider's contribution to form AMMRIC did not cause it to incur any amount of interest expense that could be viewed as unnecessary. After issuing its bonds in 1985, the Provider incurred no borrowing in its 1986, 1987, 1988 or 1989 fiscal years. Thus, there is no outstanding borrowing during fiscal year 1989 which could have been avoided had the Provider not made the contribution to create AMMRIC.

The Provider asserts all of the interest expense offset during the 1989 fiscal year was related to the Provider's 1985 bond issuance. The interest expense on those bonds had been determined by the Intermediary to be necessary. As the Intermediary's witness recognized at the hearing, interest expense which is determined to be necessary does not become unnecessary as a result of subsequent events. See, Blue Cross Administrative Bulletin No. 1186, and Pioneer Hospital v. The Travelers Insurance Co., PRRB Decision No. 83-D23.[8] Thus, the interest on the Provider's 1985 bonds incurred during the 1989 fiscal year was necessary and remained necessary irrespective of the events occurring after fiscal year 1989. Accordingly, it was improper for the Intermediary to offset any of such interest expense.

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[8] Pioneer Hospital v. The Travelers Insurance Co., PRRB Decision No. 83-D23, Jan. 7, 1983 , CCH Medicare and Medicaid Guide ¶ 32,400, aff'd issues 1&2, rev'd issue 3, HCFA Admr Decision, Mar. 3, 1983, CCH Medicare and Medicaid Guide, ¶ 32,472.

Further, with respect to both fiscal years 1989 and 1991, the Provider contends that the amount offset was excessive. The Provider's portion of the net income of AMMRIC was approximately 25% of its contribution to AMMRIC for both fiscal years 1989 and 1991. On the other hand, the interest rate the Provider paid on its borrowing during fiscal year 1989 was 6.0%, and the interest rate paid by the Provider on its borrowing during fiscal year 1991 was 7.29%. Thus, if the Provider had reduced its outstanding debt in fiscal year 1989 by the full amount of its contribution to AMMRIC, its interest expense would have been reduced by only 6% of $1,115,000, or $66,900 (as compared to $252,273 offset by the Intermediary). Similarly, if the Provider's outstanding borrowing during fiscal year 1991 were reduced by $1,115,000, the Provider's interest expense would have been reduced by $80,280 (compared to $279,694 offset by the Intermediary). Thus, the Intermediary's adjustment substantially overstated the amount of the interest expense incurred by the Provider that could potentially be deemed to have been unnecessary.

In response to the Intermediary's position that the Medicare regulations require an investment income offset, and contain no flexibility to avoid and reduce an offset when the rate of return on an investment significantly exceeds the interest rate being paid by a Provider, the Provider emphasizes that the Board has permitted the Medicare program to avoid the literal meaning of the regulations when the application of the regulations in accordance with their literal meaning would have conflicted with the agency's objective. See The Trustees of Indiana University Hospital v. United States, 618 F.2d 736 (U.S. Court of Claims 1980); Clark v. United States, 599 F.2d 411 (U.S. Court of Claims 1979); United States v. American Trucking Association, 310 U.S. 534 (1940); Northwest Hospital, Inc. v. Hospital Services Corp., 687 F.2d 985 (7th Cir. 1982); South Boston General Hospital v. Blue Cross of Virginia, 409 F.Supp. 1380 (W.D. Va. 1976). The overriding purpose of the investment income offset rule is to ensure that unnecessary borrowing are not reimbursed. The Board has the flexibility to interpret the Medicare regulations in such a manner as to avoid the disallowance of necessary interest expense, and thereby to reduce the amount of any investment income offset so that only that portion of the Provider's interest expense that is unnecessary is eliminated.

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that its adjustment was proper and in accordance with the Medicare regulations at 42 C.F.R. § 413.153(b)(2)(iii) which requires interest expense be offset by investment income. The Intermediary argues that the Provider's contribution to AMMRIC was clearly an investment, and that the income earned as a result of that investment must be offset from the Provider's allowable interest expense.

The Intermediary argues that the Private Placement Memorandum ("PPM") issued by the Provider when soliciting prospective limited partners from among the physician community [i.e., those on its medical staff or with privileges] clearly stated that the business objective of the venture was to generate revenues and profits for the general and limited partners. Moreover, it was projected that the Provider's patients would only comprise about 10% with the inference that 90% of the profits would be divided among the partners.

The Intermediary rejects and challenges the four primary contentions of the Provider.

Contrary to the Provider's main argument, the Intermediary contends that the central issue is not whether there was a transaction between related parties because that has no significant impact on the basis of the adjustment. The central issue is whether the Provider made an investment in AMMRIC and earned a return on that investment. If so, the regulations require an offset against claimed interest expense. The Intermediary states the related party rule is not intended to shelter income earned by a provider through an investment in a related organization.

The Intermediary also states that HCFA Pub. 15-1 § 202.2.c specifically describes the method used to calculate the offset on a provider's investment with a related party. Therefore, there is no support for the Provider's assertion.

The Intermediary notes, however, that it made an adjustment to remove the profit related to Provider's 8% share of MRI patients for FY 1989; but it did not make such an adjustment for FY 1991. Any adjustment, if appropriate, would be nominal.

The Intermediary contends that the Provider's second argument was completely without merit. The Provider asserted that no offset was required because the AMMRIC activities and revenues were related to patient care. The Intermediary argues the assertion is not relevant; and assuming it was, the activities were not patient related. The Intermediary states that for purpose of determining whether an activity is patient related, the issue becomes whether the particular activity was related to the care of the provider's patients. Since AMMRIC was operated as a free standing entity, and furnished most of its services to individuals who were not patients of the Provider at the time the services were received, AMMRIC's activities cannot be considered patient care related for the Provider.

The Intermediary rejects the Provider's argument concerning unnecessary borrowing because it is simply incorrect because it merges two separate concepts. The Provider stated the intended purpose of the investment income offset rule was to avoid payment of interest on unnecessary borrowing ("UB") which is untrue. The Intermediary states there is no UB issue in this case, and the Provider's argument is either incorrect or just not relevant. The Provider's reference to the Pioneer Hospital case involved an UB situation which has no application to the this case.

The Intermediary repudiates the Provider's argument that the amount of the offset was erroneous and excessive because AMMRIC's profits involved a very high rate of return [25%] as compared to the interest rates paid on its indebtness of 6.0 to 7.29%. Thus, the offset imposed a harsh penalty which should be mitigated; and there is room for flexibility.

The Intermediary asserts that it is required under the regulations to offset investment income from interest expense regardless of the return earned by the investment income compared to the rates involved on the interest expense being offset. The Intermediary contends that the regulations do not provide any flexibility envisioned by the Provider.

The Intermediary also rejects the assertion that the Board has the flexibility to interpret the Medicare regulations in such a manner as to avoid the disallowance of necessary interest expense, and thereby reduce the amount of any investment income offset so that only a portion of the Provider's interest expense that is unnecessary is eliminated. Again, there seems to be the confusion of UB which has no application.

CITATION OF LAW, REGULATIONS, AND PROGRAM INSTRUCTIONS:

1. Law - United States Code ("U.S.C.") 42 U.S.C.:

§ 1395x(v)(1)(A)	-	Reasonable Cost

2. Regulations - Code of Federal Regulations ("C.F.R.") 42 C.F.R.:

§ 405.1801 et seq.	-	Provider Reimbursement Determinations and Appeals
§ 413.5 et seq.	-	Cost Reimbursement - General
§ 413.9 et seq.	-	Cost Related to Patient Care
§ 413.17 et seq.	-	Cost to Related Organizations
§ 413.20 et seq.	-	Financial Data and Reports
§ 413.24 et seq.	-	Adequate Cost Data and Cost Finding
§ 413.53 et seq.	-	Determination of Cost of Services to Beneficiaries
§ 413.153 et seq.	-	Interest Expense

3. Program Instructions - Provider Reimbursement Manual (HCFA Pub. 15-1):

§ 202 et seq.	-	Interest Expense
§ 1000 et seq.	-	Cost to Related Organizations

4. Cases:

Cabell Huntington Hospital (Huntington W. Va.) v. Blue Cross and Blue Shield Association/Blue Cross and Blue Shield of Virginia, PRRB Dec. No. 96-54, August 23, 1996;

Cabel Huntington Hospital v. Shalala, 101 F. 3d 984 (4th Cir. 1996).

Clark v. United States, 599 F.2d 411 (U.S. Court of Claims 1979).

Florida Medical Center v. Blue Cross and Blue Shield Assn./Blue Cross and Blue Shield Florida, PRRB Dec. No. 94-D51, June 29, 1994, CCH Medicare and Medicaid Guide ¶ 42,542, aff'd issues 1,2,4,&5 and Mod #3, HCFA Admr Decision, Aug. 23, 1994, CCH Medicare and Medicaid Guide, ¶ 42,708.

Pioneer Hospital v. The Travelers Insurance Co., PRRB Decision No. 83-D23, Jan. 7, 1983 CCH Medicare and Medicaid Guide ¶ 32,400, aff'd issues 1&2, rev'd issue 3, HCFA Admr Decision, Mar. 3, 1983, CCH Medicare and Medicaid Guide, ¶ 32,472.

Northwest Hospital, Inc. v. Hospital Services Corp., 687 F.2d 985 (7th Cir. 1982).

St. Mary's Hospital v. Blue Cross and Blue Shield Association/ Trigon Blue Cross and Blue Shield, PRRB Dec. No. 99-D6, November 17, 1998.

South Boston General Hospital v. Blue Cross of Virginia, 409 F.Supp. 1380 (W.D. Va. 1976).

The Trustees of Indiana University Hospital v. United States, 618 F.2d 736 (U.S. Court of Claims 1980).

United States v. American Trucking Association, 310 U.S. 534 (1940).

5. Other:

Blue Cross Administrative Bulletin No. 1186.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board, after consideration of the facts, parties' contentions, evidence presented, testimony elicited at the hearing, and posthearing briefs, finds and concludes that the Intermediary properly determined the net income from AMMRIC was investment income which was required to be offset from the Provider's otherwise allowable interest expense pursuant to the provisions of 42 C.F.R. § 413.153(b)(2)(iii).

The Board makes the following findings of fact:

1. April 17, 1987, the Provider created a limited partnership which formed AMMRIC, a free standing facility on the Provider's premises, to provide MRI services.

2. The Provider was a general partner with a 72% interest and the physician limited partners had a 28% interest.

3. A Private Placement Memorandum ("PPM") used to solicit limited partners stated at p.28 that the business objective was to generate revenues and profits for the general and limited partners.

4. AMMRIC is an independent legal entity with its own Medicare supplier number, agreement, and billing function, and it does not operate under the Provider's hospital license.

5. The Provider and AMMRIC are related organizations.

6. The Provider's patients represented about 8% of the MRI services of AMMRIC in 1989 and an undisclosed amount in 1991.

7. The Intermediary determined the total AMMRIC investment income to be about $438,200 and $387,800 in FYEs 1989 and 1991; and about $274,200 and $279,700 was allocated to the Provider.

8. The Intermediary offset the investment income allocated to the Provider against allowable interest expense as follows:

- 1989 offset was about $252,300 after reducing the allocated profit by 8% for the MRI services rendered to the Provider's patients (8% x $274,200 = $21,900).

- 1991 no reduction was made; and the entire allocated profit of about $279,700 was offset.

The Board disagrees with the substance of all the Provider's arguments.

The Board finds the Provider made two faulty assertions concerning the fact the entities were related. First, the Board rejects the Provider's argument that since the entities were related, AMMRIC must be treated as an operating unit of the Provider and consider the income as earned from operations rather than from an investment. This assertion was augmented by a second defective assertion that transactions between related organizations should be ignored for Medicare reimbursement purposes because the related organization must be treated as if it were part of the Provider itself. [That assertion is only partially correct as discussed in the following paragraph.]

The Board agrees the parties were related; but, finds the Provider's assertions regarding the Medicare related organization (RO) principles have been misinterpreted and misplaced. The RO principles at 42 C.F.R. § 413.17 only become applicable when a provider obtains "items of services, facilities, or supplies" from an entity owned or controlled by the provider. Thus, when the provider obtains items of services or supplies from a RO, then the provider treats the items obtained as if it were from itself to determine only the cost of such items for Medicare reimbursement. The Board finds the Medicare RO principles have no relevance unless a buyer-seller affiliation exists which was absent in this case, except for the 8% of MRI procedures performed for the Provider's patients which were billed to the Provider. Thus, the Provider may claim the financial data related to the 8% of MRI services billed, to determine the cost thereof pursuant to the RO principles.[9] The remaining 92% of the distributed profit from the MRI venture pertains to non-provider activities and is not related to the Provider's rendering of patient care. The Board rejects the Provider's assertion that AMMRIC's activities were related to the Provider's patient care activities because it did not, except for 8% of its patients receiving MRI services. Thus, the Provider's share of the profits related to the 92% of MRI procedures represents investment income that must be offset against the otherwise allowable interest expense as required by the regulations at 42 C.F.R. § 413.153(b)(2)(iii) for the years in dispute.

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[9] 42 C.F.R. § 413.17 et seq.

The Board finds the crucial reality of this case is that the Provider made an investment in an MRI venture with others as evidenced by the statement at p.28 of the Private Placement Memorandum that "the business objective was to generate revenues and profits for the general and limited partners." Hence, there was an basic intention to have a business relationship and to produce profits which equates as an investment; and the provision of MRI services for the Provider and the community became an auxiliary benefit.

The Board disagrees with the Provider's alleged perception that both internally and the public views AMMRIC as part of the Provider's operations. Obviously, from a legal standpoint that is untrue; and such a perception in this dispute is irrelevant.

The Board finds a pivotal determining factor in this case was the fact AMMRIC was a separate legal entity, with an independent Medicare: i) agreement, ii) Provider number, iii) medical records, and iv) billing for all services performed. The Board notes the entire financial spectrum of rendering MRI services were recorded in the financial records and ultimately reflected on the financial statements of AMMRIC; such as costs, billed charges and receipts of payments, etc.

As stated, the Board agrees the parties were related; and notes the Provider's financial statement reported its investment in AMMRIC under the equity method of accounting as permitted under generally accepted accounting principles which underscores the reality that this was an investment.

The Board finds that two other Provider assertions were simply misplaced and have no merit. The first misplaced assertion stated that the investment income offset rule was included within the regulations and manual provisions pertaining to the definition of "necessary borrowing" to avoid Medicare reimbursement for unnecessary borrowing, i.e., excess funds;[10] therefore, the offset had no application in this case. The Board does not agree with this premise, and notes there was no dispute regarding unnecessary borrowing in this case; hence, it is irrelevant.[11] However, to then claim the offset rule has no application, is without merit. Lastly, the Provider asked that the Board use its flexibility to reduce the amount of the offset based upon the application of a more reasonable [and lower] investment interest rate (6.0 - 7.29% as earned on bonds) rather than the bountiful 25% rate earned by AMMRIC. The Board finds it has no authority to grant this request pursuant to the law and regulations.

In summary, the Board finds and concludes that based on the above statements and the substantial evidence in the record:

1. the Provider's contribution and status as general partner in the MRI venture of AMMRIC was a business investment;

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[10] The citation of 5 court cases regarding excess funds was accurate but irrelevant.

[11] The Board notes that the regulation section requiring the offset requirement also provides for four exceptions which does not include directly or by reference any transactions with a related party.

2. the net[12] yearly profits from this venture represents investment income as defined in HCFA Pub. 15-1 § 202.2; and

3. such net income must be offset against the Provider's otherwise allowable interest expense for the years in dispute as stated at 42 C.F.R. § 413.153(b)(2)(iii).

The Board notes the decision in this case is supported by the court cases of Cabell[13] and St. Mary's Hospital.[14]

DECISION AND ORDER:

The Intermediary's adjustment to offset the net investment income earned from a related organization against the Provider's claimed interest expense was proper. The Intermediary's adjustments for FY 1989 are affirmed and for FY 1991 are modified. For FY 1991 the Intermediary should reduce the offset by the percentage of the Provider's patients receiving MRI services consistent with the Intermediary's adjustment in FY 1989.

Board Members Participating:

Irvin W. Kues
James G. Sleep
Henry C. Wessman, Esq.
Martin W. Hoover, Jr., Esq.
Charles R. Barker

Date of Decision: April 29, 1999

FOR THE BOARD:

Irvin W. Kues
Chairman

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[12] "Net" means after reducing the amount received by the percentage of Provider patients serviced, e.g. 8% for 1989.

[13] Cabell Huntington Hospital (Huntington W. Va.) v. Blue Cross and Blue Shield Association/Blue Cross and Blue Shield of Virginia, PRRB Dec. No. 96-54, August 23, 1996; Cabel Huntington Hospital v. Shalala, 101 F. 3d 984 (4th Cir. 1996).

[14] St. Mary's Hospital v. Blue Cross and Blue Shield Association/ Trigon Blue Cross and Blue Shield, PRRB Dec. No. 99-D6, November 17, 1998.