PROVIDER REIMBURSEMENT REVIEW BOARD
HEARING DECISION

ON-THE-RECORD
2000-D14

PROVIDER -St. Joseph Hospital and Medical Center, Phoenix, Arizona

Provider No. 03-0024

vs.

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

DATE OF HEARING-
September 9, 1999

Cost Reporting Period Ended - June 30, 1992

CASE NO. 95-1201

INDEX

ISSUES:

1. Were the Intermediary's adjustments excluding certain interest expense proper?

2. Were the Intermediary's adjustments grossing up days and charges for employee patients proper?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

St. Joseph Hospital and Medical Center ("Provider") is a short-term acute care hospital located in Phoenix, Arizona. It filed its Medicare cost report for the fiscal year ended June 30, 1992, ("FY 92") including various costs and statistics that are currently under appeal. Blue Cross and Blue Shield of Arizona ("Intermediary") issued a Notice of Program Reimbursement which included audit adjustments to the Provider's filed cost report. The Provider appealed several of these adjustments to the Provider Reimbursement Review Board ("Board"). The Provider's filing meets the jurisdictional requirements of 42 C.F.R. §§405.1835 - .1841. The Provider is represented by Brad Gentry, CPA, of Catholic Healthcare West. The Intermediary is represented by Bernard M. Talbert, Esquire, of Blue Cross and Blue Shield Association. The aggregate amount in dispute for both issues is approximately $550,000.

Issue No. 1 - - Interest Expense

On April 17, 1991, the Provider borrowed $57.5 million of Phase V Industrial Development Authority Bonds.[1] Page 33 of the Official Statement states the uses and sources of funds from this borrowing. The monies were essentially to: (1) refund $13 million of 1985 bonds, (2) fund the purchase of new assets of $12 million, and (3) remodel existing structures and purchase equipment for $32.5 million. The balance of funded depreciation available on or around the time of the Phase V borrowing was $1,389,760.[2] The Intermediary disallowed the interest expense on the $32.5 million because it considered the borrowing as unnecessary. This resulted in a reduction in Medicare reimbursement of approximately $500,000. For FY 92 a capital budget of $36.5 million was submitted to the Provider's board of directors by the Provider's officers.

PROVIDER'S CONTENTIONS:

The Provider contends that in accordance with Provider Reimbursement Manual, HCFA Pub. 15-1 ("HCFA Pub. 15-1") § 202.2, in order for interest to be necessary it must be incurred on a loan to satisfy a financial need, and the purpose must be related to patient care. It is clearly evident that the

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[1] See Provider Exhibit 10.

[2] See Provider Exhibit 11-Funded Depreciation as of February 1991.

total capital commitments of $36,500,000 cannot be solely financed with $1,389,760 of funded depreciation. In accordance with HCFA Pub. 15-1 §202.2A, the question of financial need to borrow funds is performed at the time of borrowing and not subsequent to the borrowing date of issuance. Therefore, the Intermediary cannot disallow the interest on borrowing because of the increase in funded depreciation from 1991 to 1994. This increase is not revelant to the issue of a financial need to borrow for capital purposes in April 1991.

The Provider notes that another Intermediary position is that if the interest expense is deemed allowable, it should be capitalized in accordance with HCFA Pub. 15-1 §206. The Provider contends that this manual section addresses construction and enlargement of facilities.[3] Per Provider Exhibit 12, the capital needs were for remodeling projects which did not expand the exterior confines of the hospital plant. In accordance with Ravenswood Hospital v. Blue Cross Association/Health Care Service Corp., PRRB Dec. No. 79-D58, October 3, 1979, Medicare & Medicaid Guide (CCH) ¶ 30,139 ("Ravenswood"), interest expense for remodeling existing structures could be included in the cost report as a current expense rather than capitalized where patient care services and revenue remain unaffected by the remodeling. Under these circumstances, the interest expense was related to the current care of patients.

The Provider petitions the Provider Reimbursement Review Board to require the Intermediary to revise adjustment #24 and eliminate adjustment #46 based on the financial need of the hospital to borrow monies in April, 1991 for remodeling projects.

INTERMEDIARY'S CONTENTIONS

The Intermediary contends that it is proper to disallow the interest expense incurred on the construction fund portion of the Phase V borrowing. The Provider's borrowing was unnecessary based upon various analyses submitted by the Provider related to its funded depreciation accounts. The Intermediary's review of these analyses is in Intermediary Exhibit I-2. Further, the Intermediary believes that if the Board finds the borrowing to be necessary and proper, then the issue of interest expense capitalization needs to be addressed. The Intermediary believes that the interest expense should be capitalized and amortized over the new life of the assets being renovated. The amortization would begin upon completion of the various project stages. Finally, the Intermediary notes that another part of this issue involves the determination of interest income to be offset. The Provider did not offset any investment income on its cost report due to its treatment of a loss on land write-down. The Provider is not disputing that investment income should be offset, just that the Intermediary has calculated the amount to be offset improperly. It is the Intermediary's understanding that the Provider is asking that it increase the amount of the investment income offset to account for income received on the new bond issue, should the borrowing be treated as necessary. The Intermediary believes that the interest on the new borrowing should not be offset since the interest expense on the borrowing has not

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[3] See Provider Exhibit 12.

been allowed.

The Intermediary observes that $32,500,000 was deposited into a construction fund account along with the $13,016,620 which was to be used to refund the 1985 bonds. This construction fund is held by the Provider's home office via a bond trustee and then allocated to the Provider. It should be noted that the 1985 bond refunding never occurred, yet the interest expense allocation to the Provider did stop at this point in time.

Upon reviewing the Provider's analysis of the funded depreciation account [4] the Intermediary found that the Provider was making deposits into the funded depreciation account in the exact amount as that being drawn from the construction account at the home office. In a discussion with the Provider's director of reimbursement, the Intermediary was told that the following transfers were made to the home office to pay for the 1985 debt during the 1991 fiscal year.

Funded Depreciation Account 1421	$ 8,934,700
Bond Funds Account 1415	3,132,953
Reserve Funds Account 1415	948,967
Total transfers	$13,016,620

The Provider contends that it did not have the funds available in the funded depreciation account when the debt was incurred, and that the Intermediary should not be reviewing the 1992 through 1994 funded depreciation accounts when determining the necessity of the borrowing. The Intermediary had requested a cash flow analysis of the Provider at the time of the bond issue. This has never been submitted. The Intermediary therefore had no alternative but to review the transactions which occured after the bond issue took place. These transactions appear to be extremely questionable, and the Intermediary believes that they document that the Provider's funds have been borrowed and then placed into the funded depreciation account. This resulted in overstating allowable interest expense and avoiding an investment income offset.

The Intermediary believes that the Provider temporarily transferred funded depreciation for defeasance purposes so that it was not readily available upon the incurrence of the $32,500,000 of new debt. The following Provider Reimbursement Manual sections are applicable: HCFA Pub. 15-1 §233.4, Limitation of Recognition of Costs; HCFA Pub. 15-1, § 226.C; HCFA Pub.15-1 226.D.

The Intermediary notes that during the analysis of the Provider's funded depreciation account, it found that the Provider had $13,414,913 in its funded depreciation account at March 31, 1991. This increased to $87,682,057 by July 31, 1993.[5] The Provider has maintained that the deposits into

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[4] See Intermediary Exhibit I-4.

[5] See Intermediary Exhibit I-6.

funded depreciation came from operations. This does not seem feasible since the Provider's financial statements for 1992 and 1993 show minimal profits. The Intermediary realizes that the Provider's income per its financial statements and its cash flow are not related, but it does not seem feasible for the disparity between the two to be so sizable. This makes the transaction being discussed even more questionable. The Provider has not commented further on the sources of funds for the funded depreciation accounts.

The Intermediary notes that the Provider cites the Ravenswood Board decision in its position paper. This case dealt specifically with the issue of capitalizing interest expense related to remodeling. In that case, the provider did not expense anything for financial statement purposes, yet the intermediary capitalized interest for Medicare reimbursement. The Board ruled that the interest was to be expensed and not capitalized. The Intermediary notes that this situation does not appear to be similar to the Provider's situation. The Provider has capitalized $599,000 for financial statement purposes. It then added this back onto the cost report as an operating cost via a Worksheet A-8 adjustment. Reading the Generally Accepted Accounting Principles guide Financial Accounting Standard ("FAS") -34 states:

> FAS-34 does not allow the capitalization of interest cost for: (a) assets that are ready for their intended use or that are actually being used in the earning activities of a business and (b) assets that are not being used in the earning activities of a business and that are not undergoing the activities required to get them ready for use.

FAS-34, Par. 10.

The Intermediary is questioning the Provider's reasoning for stating that the project consisted of renovations. If the project had been strictly renovation related, the Provider's CPA firm could not allow the capitalization of interest for financial statement purposes. An audit of a provider's books by a certified public accounting firm normally includes a complete analysis of interest expense, including capitalized interest. The Intermediary does not understand the Provider's contention that there was no new construction when the audited financial report capitalized interest $599,000 under FAS-34.

Issue No. 2 -- Employee Day & Charges Gross-Up

Facts:

The Provider offers a flex account for its employees. This includes employee health, disability insurance, life insurance, vision, dental, and other various employee benefits. The Provider accounts for all of these various expenses through one general ledger account entitled "Flex". In FY 92, the Provider recorded $7,076,422 of expenses in this account.

The Provider treated a portion of the health insurance recorded in this account as self-insured health insurance. Program instructions for such self-insurance state that days and charges related to self-insured activities should be removed from total days and charges on the Medicare cost report for purposes of routine and ancillary cost reimbursement only.[6] Accordingly, the Provider reduced total patient days by the number of patient days associated with employees and also reduced total charges related to these same employees. The Provider did not make a corresponding reduction to the amount of costs in the flex account for this activity.

The Provider has established a trust fund entitled "St. Joseph's Hospital and Medical Center Voluntary Employees' Beneficiary Association Trust." The trust was established in accordance with §501(c)(9) of the Internal Revenue Code. The purposes of this trust fund, per the Trust agreement, is "...to receive contributions from the Corporation and its employees and to distribute benefits under the Plans to such employees and their dependents."[7] Per the Provider's IRS form 5500 filing,[8] total contributions to the plan were $8,691,273 and $8,848,968 for the calendar years 1991 and 1992, respectively. Interest earned on these funds for 1991 and 1992 were $59,361 and $117,486, respectively. This income was not used in the calculation of net investment income offset. The Provider maintains control over the trust fund and directs the trustee to make payments when necessary, in accordance with the various benefit plans adopted by the Provider.

The Intermediary made audit adjustments to add back the charges and patient days related to the Provider's employees. The Intermediary believes that the Provider has not adequately documented the employee patient days, charges, and costs and therefore has reimbursed the Provider based upon the amount that the Provider has recorded in its flex account on the Provider's general ledger. The adjustments resulted in a reduction in Medicare reimbursement of approximately $50,000.

PROVIDER'S CONTENTIONS:

The Provider contends that the Intermediary should have excluded the charges, days and costs related to employees that were patients of the Provider. The Provider has determined expenses for health care of employees based on the provider's cost accounting system.[9] As part of Blue Cross and Blue Shield Administrative Bulletin 1404, commercial insurance and self insurance plans that meet the conditions of HCFA Pub. 15-1 § 2162.7 should be treated as allowable insurance expense with the employee charges and days gross in the cost report. However, the Provider's situation does not meet the

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[6] See Intermediary Exhibit I-7.

[7] See Intermediary Exhibit I-8.

[8] Id.

[9] See Provider Exhibit 13 for a listing of proposed costs, charges and days elimination from the cost report.

conditions established in HCFA Pub. 15-1 § 2161.7B2. While the trustee of the self insurance trust and not the Provider held legal title to the trustees' assets, the Provider was responsible for the administration of the plan. The trustee was subject to the direction of the Provider as to when to distribute trust funds.[10] Furthermore, the trustee was subject to the direction of the Provider as to the investment and reinvestment of trust funds.[11] Finally, the trustee did not have control over the administration of the plan.[12]

The Provider further contends that HCFA Pub. 15-1 §332.1 addresses the treatment of employee health costs when treated at the Provider's site. Since the costs of care are not properly recognized as Medicare expenses, the cost, charges, and days should be excluded from the cost report. This is similar to the decision in Methodist Medical Center of Illinois v. Sullivan, No. 87-1283 (D.C.D. IL. 1989). Therefore, the Provider petitions the Board to require the Intermediary to exclude charges, expense and total patient days for employees receiving health care at the Provider's site.

INTERMEDIARY'S CONTENTIONS:

The Intermediary believes that if the Provider can provide a complete accounting of employee benefit days, charges, and expenses as recorded in the flex account, then the reduction of days and charges should be made. In addition, the Intermediary believes that if the Provider is to account for employee health services in this manner, then it would only be proper to include the investment income earned on the trustee funds in the net investment income calculation. The Provider should not be allowed to claim self-insurance contributions, transfer monies to a trustee account which is to be used to pay for health care and then shelter the income related to this trust fund.

The Intermediary observes that the Provider has stated that the Intermediary should not treat the health insurance costs as self insurance because the Provider was the administrator of the trustee fund. The Provider states that HCFA Pub 15-1 § 2162 dealing with self insurance funding requirements should not be utilized, and that HCFA Pub. 15-1 § 332 dealing with employee health plans should be implemented. The Intermediary does not dispute the fact that the Provider maintains control of the trust assets, and that they dictate the assets' use. The Intermediary believes that the Provider has neglected to review the entire §2162. This section further states the following:

> PRM1, §2162.7(E)-Trust Mechanism Applicable to Employee Health Care. If the provider wishes, the program will recognize the establishment of self insurance funds for employee health care in

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[10] See trust agreement - Article 2.05, Page 4 and 2.06, page 5 at Exhibit 16.

[11] See trust agreement - article 2.05, Page 4 and 2.06, page 5 Exhibit 16.

[12] See Article 2. 01, Page 3 of the trust.

> accordance with the provisions of §501(c)(9) of the Internal Revenue Code. This code section grants a tax free exemption to funds established in trust, provided the funds are used to pay for life, sickness, accident or other employee benefits.
>
> Application of this Internal Revenue procedure would allow a provider to establish its employee health care self-insurance fund without relinquishing legal title to the fund to an independent fiduciary. In addition, fund trustees may also be employees of the provider, as long as the employees act independently in their administration of the trust. All other conditions applicable to self-insurance elicited in this manual section, however, will be applicable to employee health care trusts established under this -Internal Revenue procedure, i.e., payments by fiduciary, termination, reporting soundness of the fund, etc.

HCFA Pub 15-1 § 2162.7(E)

The Intermediary believes that since the Provider established this trust under the Internal Revenue Code § 501(c)(9) guidelines, then the above section must be upheld. It is the Intermediary's contention that the self insurance trust is an allowable trust, and that the amounts the Provider expenses and funds are allowable, provided that over-funding does not exist. The Intermediary reviewed the funding level versus the expense at Workpaper E-9.4[13] to determine the amount of allowable cost for the cost reporting period under review. Since the Intermediary has determined the amount of costs to be allowable for cost reporting purposes, the Provider should not remove any days or charges from the cost report.

The Intermediary observes that the Provider has accounted for its employee health insurance on its general ledger by combining all expenses with other "Flex" account items. The trustee agreement finds the following items as being included in the trust funds: medical, dental, vision, medical reimbursements, dependent care reimbursements, group-term employee and dependent life insurance, accidental death and dismemberment insurance, long-term disability, and paid time-off benefits. The Provider's general ledger contains an account containing expenses of $7,076,422, and the Intermediary attempted to review this account in detail during the audit. Two audit adjustments were made during this review which reduced the Provider's allowable costs by $599,686. These particular adjustments are not being disputed by the Provider.

The Intermediary contends that the Provider has been unable to document how much of the expenses in this account actually relate to the employee discount days. They have instead asked that the Intermediary remove expenses based upon the Provider's cost accounting system. The Intermediary

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[13] See Exhibit I-9.

believes that this is an inaccurate method of identifying costs that are included in the general ledger. The Provider should have an accurate mechanism of identifying the exact costs that have been included in the general ledger related to employee health coverage provided at the Provider. The Intermediary believes these costs have already been included in the "Flex" account, and yet the Provider has included a schedule from the cost accounting system asking the Intermediary to utilize this when estimating the costs included in the general ledger related to employee health insurance. The schedules submitted do not appear to be auditable, and the costs cannot be traced to the general ledger of the Provider. Why would the Intermediary remove estimated costs from the general ledger when actual costs should be identifiable?

The Intermediary notes that to ask it to make a cost adjustment based upon a cost accounting system is not reasonable. The Provider should prepare an analysis of the "Flex" account and substantiate the expenses that are included in the general ledger related to employee discount days before any adjustment could be proposed. Based upon this alone, the Intermediary should not allow the Provider's methodology of removing patient days and charges from the cost report.

CITATION OF LAW, REGULATIONS AND PROGRAM INSTRUCTIONS:

1. Law

   A - 42 U.S.C:

   §1395(x)(v)(1)(A) - Reasonable Cost

   B - Internal Revenue Code

   §501(c)(9) - Non-Profit Trust Requirements

2. Regulation - 42 C.F.R.:

   §§405.1835-.1841 - Board Jurisdiction

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

   §202.2 et seq. - Necessary

   §206 - Interest During Period of Construction

   §226 C - Restrictions

   §226 D - Investments or Transfers

§233.4 - Limitation on Recognition of Costs

§332 - Allowance to Employees

§332.1 - Method for Including Unrecovered Cost

§2162 et seq. - Provider Costs for Malpractice and Comprehensive General Liability Protection, etc.

§2162.7 et seq. - Conditions Applicable to Self Insurance

4. Cases:

Ravenswood Hospital v. Blue Cross Association/Health Care Service Corp., PRRB Dec. No. 79-D58, October 3, 1979, Medicare & Medicaid Guide (CCH) ¶30,139.

Methodist Medical Center of Illinois v. Sullivan, No. 87-1283 (D.C.D. IL. 1989).

5. Other:

A - Financial Accounting Standards:

No. 34 - Capitalization of Interest Cost

B - Blue Cross and Blue Shield Administrative Bulletin:

No. 1404 - Clarification of Revision 276 To The PRM, Part I Regarding Insurance For Employee Health Care

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board, after considering the law, regulations, program instructions, facts, parties' contentions and evidence find and conclude as follows:

Issue No. 1 - Interest Expense:

After reviewing the entire record, including exhibits, the Board finds no evidence to support the necessity of borrowing by the Provider. Further, there is no evidence to support how the Provider spent the loan proceeds. There is no analysis to support the cash flow in and out of funded depreciation. The Board observes that the date of borrowing was April 17, 1991. The Provider used

the $1,389,760 balance[14] in the funded depreciation account to support its necessity of borrowing calculation. That amount, however, was the balance as of February 1991. The Intermediary's workpaper[15] shows a balance as of March 31, 1991 in funded depreciation of $13,414,913. There was no balance placed into evidence as of the date of borrowing. The Intermediary had requested cash flow analyses to establish the sources and uses of funded depreciation. None were offered by the Provider. Based on this, the Board denies the interest expense claimed by the Provider. A provider is responsible for supporting its claimed cost, and it has not done so in this case. The Intermediary also addressed the issue of whether a portion of the interest expense should be capitalized if the interest expense were deemed allowable by the Board. This argument is moot since the Board disallowed the interest expense due to lack of documentation.

Issue No. 2 - Employee Day and Charges Gross Up

This issue concerns the proper treatment for the reimbursement of employee health benefits offered by the Provider. The Provider wished to use HCFA Pub. 15-1 §332.1, which provides Medicare's method for including the unrecovered costs of services rendered by a provider to its employees. The Provider reduced patient days and charges related to its employees from the cost reimbursement calculation. It did not remove or adjust any of the costs claimed. The Intermediary allowed total contributions to a self-insurance trust fund established by the Provider under HCFA Pub. 15-1 §2162.7. However, it added back Medicare days and charges to the cost finding process in its audit adjustments.

The Board finds that either of the above program instructions can be used to determining allowable employee benefit health care costs. The Board notes that the Provider did not properly apply HCFA Pub. 15-1 §332. It should have reduced allowable costs by amounts actually charged to the employees. That was not done. Further, such allowances were not determinable or auditable.

The Board further finds that what the Intermediary did was reasonable and correct. It included total trust fund payments and Medicare cost and charges for employees in the Medicare cost computation. The trust fund meets the requirements of HCFA Pub. 15-1 §2162.7. Thus, the contribution costs are allowable. Since the Provider could not establish charge allowances relevant to employees, the Intermediary's only method for reimbursing costs related to the care of its employees was through the recognition of the payments to the self insurance trust fund. Further, it should be noted that the Provider's methodology resulted in a double payment. It first received payment by including all costs related to employees in its cost finding calculation. It received additional payment by reducing charges and days from the statistics used to calculate Medicare reimbursement. This has the effect of increasing

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[14] See Provider Exhibit 11.

[15] See Intermediary Exhibit I-6

the Medicare per diem and Medicare's share of costs of other services. The Intermediary's method of reinstating days and charges related to employees eliminates this "double dip."

DECISION AND ORDER:

Issue No. 1 - Interest Expense

The Provider did not properly establish the necessity of borrowing for the April 17, 1991 loan. The interest expense related to this borrowing is not allowable. The Intermediary's adjustment is affirmed.

Issue No. 2 -- Employee Day and Charges Gross -Up

The payments by the Provider to its self insurance trust fund are allowable. The days and charges for employees should be included in the Medicare reimbursment calculation. The Intermediary's adjustment is affirmed.

BOARD MEMBERS PARTCIPATING:

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

Date of Decision: January 11, 2000

FOR THE BOARD:

Irvin W. Kues
Chairman