PROVIDER REIMBURSEMENT REVIEW BOARD
HEARING DECISION

2001-D9

PROVIDER -
Ohio Valley Medical Center
Wheeling, WV

Provider No. 51-0039

vs.

INTERMEDIARY -
Blue Cross and Blue Shield Association/
Trigon Blue Cross Blue Shield

DATE OF HEARING-
May 14, 1997

Cost Reporting Period Ended -
December 31, 1988

CASE NO. 92-0111

INDEX

ISSUE:

Was the Intermediary=s analysis and application of the Medicare ASpend down@ (AS-D@) procedure for curing $4 million dollars of unnecessary borrowing (AUB@) proper?[1]

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

General Facts:

Ohio Valley Medical Center (AProvider@) is a 331-bed acute care, voluntary non-profit, hospital located in Wheeling, West Virginia. The Provider's fiscal intermediary is Trigon Blue Cross Blue Shield ("Intermediary").

In October 1985, the Provider incurred about $27.7 million[2] in debt by issuing bonds intended for capital purposes. The net proceeds of about $27.5 million was used primarily for the defeasance of the 1978 bond issuance of $23.2 million and for the reimbursement of project costs of about $4 million. The following table summarizes the use of the Bond net proceeds ($27.5) and funds released from the 1978 bond issuance ($3.4) for a total of about $30.9 million:

[1]Note: The initial challenge to the Intermediary=s UB determination was abandoned during the hearing and is no longer an issue.

[2]Intermediary Exhibit I-1, 1985 W. Va. Bonds-Source and Use:

Sources of Funds:		
Par Amount of 1985 Bonds		$27,755,000
Less--Original Issue Discount		208,700
Net Proceeds		27,546,300
Released Funds from Bonds Defeased		3,430,231
Total Sources		30,976,531
Use of Funds:		
Defeasance of 1978 Bonds Refunded	$23,153,042	
Reimbursement of Project Costs	4,000,000 (Unnec Det.)	
Debt Service Reserve Fund	2,883,000	
Cost of Issuance and Underwriters' Disc.	940,489	
Total Uses	$30,976,531	

Use of Funds:

Defeasance of 1978 Bonds Refunded	$23,153,042	
Reimbursement of Project Costs		4,000,000 [3]
Debt Service Reserve Fund		2,883,000
Issuance Cost and Underwriters' Disc.	940,489	
Total Use of Funds		$30,976,531

At the time of the borrowing, the FDA balance was about $3,118,000 [Intermediary Exhibit I-1, pp 3-6], and the Intermediary determined this balance to be Aavailable@ since it was not contractually committed.

Initially, the Intermediary did not question the 1985 borrowing for fiscal years (FY) 1985, 1986, 1987, 1988, and 1989. In 1992, the Intermediary performed a capital audit for FY 1990 resulting in the reopening of FY 1987, 1988 and 1989.

The Intermediary determined that: 1) $4 million of the 1985 borrowing was "unnecessary;" and 2) even though $3,895,000 of this $4 million was added to the Provider's existing FDA (of $3.1 million), it was determined to be an invalid deposit to the FDA. The balance of the $4 million, $105,000, was transferred to operating funds for past bond costs [Intermediary Exhibit I-3].

For FY 1988, the continuing effect of these two determinations resulted in a proportionate disallowance of the allowable interest expense related to the unnecessary borrowing ("UB") of about $367,800;[4] and an offset of a portion of the interest income earned on the FDA against allowable interest expense.

The interest expense disallowed was determined by establishing a ratio percentage [between the UB/and the total borrowing] then applying it to the total fiscal year (AFY@) 1988 interest expense. Further adjustments were made related to the FDA and the curing of the UB. With regard to the curing of the UB, the Intermediary determined that: i) in October 1986, $54,573 was spentdown for capital purposes, ii) $3,483,094 was spentdown for A&G purposes, and iii) no recognition of principal repayments in 1986 or 1987. The Provider disagreed with items ii) and iii).

The Intermediary reaudited the Provider's Capital-PPS base period, analyzed the FDA activity and determined that:

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[3] Intermediary determined this amount as unnecessary.

[4] Intermediary Exhibit I-7.

1) most of the UB funds had been spent in FY 1986 and FY 1987;
2) Even though Medicare has a policy permitting the "curing" of any "unnecessary borrowing," known as the "spenddown" principle by using such funds for capital purposes, the Provider did not properly apply the "spenddown" principle to cure the "unnecessary borrowing" because (a) the Provider's transactions were not for proper FDA purposes, (b) the capital transactions were not properly linked, and (c) the Provider had not maintained the FDA in accordance with Medicare manual instructions. The FDA was not properly maintained because: (i) there was a lack of documentation and connection between the withdrawals from the FDA and the purchase of assets, and (ii) interest income earned on the FDA was not properly handled.

The Intermediary issued an initial notice of program reimbursement ("NPR") on May 7, 1991 and a revised NPR on August 10, 1993 for the cost reporting period ended December 31, 1988 making several adjustments related to the stated issues. The Provider was dissatified with the Intermediary's adjustments and timely appealed the Intermediary's NPR determinations relevant to the stated issues to the Provider Reimbursement Review Board (Board) pursuant to 42 C.F.R. '' 405.1835-.1841; and it has met the jurisdictional requirements of those regulations. The estimated amount of Medicare reimbursement in controversy for the disputed issue in the FYE 1988 cost report is approximately $98,100. All other issues appealed in the FY 1988 cost report have either been administratively resolved or withdrawn by the Provider.

The Provider was represented by David W. Thomas, Esquire, of Nash & Company. The Intermediary was represented by Michael F. Berkey, C.P.A., Associate Counsel for Blue Cross and Blue Shield Association.

Relevant Medicare Statutory, Regulatory and Policy Background:

The Medicare law established 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, 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 provision that Medicare shall not pay for costs incurred by non-Medicare beneficiaries, and vice-versa, i.e., Medicare prohibits cross-subsidization of costs.

The Medicare reimbursement regulations governing interest expense and the funding of depreciation set forth the requirements that:

1) necessary and proper interest on capital indebtedness is an allowable cost; 2) such interest cost is reduced by investment income except where the income is from funded depreciation or a qualified pension fund, then there is no offset, i.e., a shelter provision; and 3) the shelter exception does not apply

if the FDA funds were not used for capital purposes. Section 413.153 of the regulations specifically governs the allowability of interest expense. During the 1988 cost reporting period, this regulation stated:

> (a)(1) Principle. Necessary and proper interest on both current and capital indebtedness is an allowable cost. . . .
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> * * *
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> (b) Definitions.
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> * * *
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> (2) Necessary. Necessary requires that the interest be --
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> (i) Incurred on a loan made to satisfy a financial need of a provider. Loans that result in excess funds or investments would not be considered necessary;
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> (ii) Incurred on a loan made for a purpose reasonably related to patient care; and
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> (iii) Reduced by investment income except if such income is from gifts and grants, whether restricted or unrestricted, and which are held separate and not commingled with other funds. Income from funded depreciation or a provider's qualified pension fund is not used to reduce interest expense. Interest received as a result of judicial review by a Federal court . . . is not used to reduce interest expense.
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> * * *
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> (c) * * *
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> (3) If funded depreciation is used for purposes other than improvement, replacement, or expansion of faci1ities or equipment re]ated to patient care, allowable interest expense is reduced to adjust for offsets not made in prior years for earnings on funded depreciation. . . .

42 C.F.R. ' 4I3.153 (emphasis added).

As stated above, the regulations at 42 C.F.R. ' 413.153(c)(3) provides for a qualification to the funded depreciation exception when the FDA funds are not used for capital purposes. If so, then allowable interest expense must be reduced not only in the current year-but-adjustments must be made for offsets not made in prior years for earnings on the FDA.

For the 1988 cost year under appeal, the Medicare regulation pertaining to the funding of depreciation did not impose any specific requirements. The regulation in 1988 stated:

> (e) Funding of depreciation. Although funding of depreciation is not required, it is strongly recommended that Providers use this mechanism as a means of conserving funds for replacement of depreciable assets, and coordinate their planning of capital expenditures with areawide planning activities of community and State agencies. As an incentive for funding, investment income on funded depreciation will not be treated as a reduction of allowable interest expense.

42 C.F.R. ' 413.134(e).

42 C.F.R. ' 413.134(e) was significantly expanded in 1991 and 1994[5] to incorporate several previous HCFA policy statements and instructions relevant to the funding of depreciation.

Where the Medicare regulations do not set forth specific requirements or fails to sufficiently explain the language or mechanics of certain reimbursement principles, HCFA has issued policy statements or program instructions providing such explanations. The Provider Reimbursement Manual, HCFA Pub. 15-1, (referred to as "program instructions"), provides further interpretation and explanation of the Secretary's reimbursement principles set forth in the regulations and/or HCFA's statements of policy. These program instructions function as interpretive rules but do not have the force and effect of law like regulations. Thus, the Board may use these interpretive rules as guides, but it is not required to follow them.

The Provider Reimbursement Manual, HCFA Pub. 15-1 ' 226 ff, provides specific requirements regarding the funding of depreciation and the mechanics of the FDA including the payment of interest on loans made from the FDA, deposits of interest earned, other deposits and withdrawals from the FDA, etc. Important provisions regarding the maintenance and mechanics of the FDA were added to HCFA Pub. 15-1 in January 1983.[6] In 1991,[7] the Medicare regulations were amended at 42 C.F.R. '

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[5] 56 Fed. Reg. 43,456 (1991); and 59 Fed. Reg. 45,401 (1994).

[6] Transmittal 279, January 1983, Medicare and Medicaid Guide (CCH) & 5124.

[7] 56 Fed. Reg. 43456 (1991).

413.134(e) to include most of these manual provisions relating to the mechanics of properly maintaining the FDA. These new provisions address such matters as unnecessary borrowing when FDA funds are available, proper and improper withdrawals from the FDA, and the elimination of the interest shelter provision for improper FDA withdrawals.

Where a provider has an "unnecessary borrowing" ("UB") situation, Medicare adopted a policy known as the "spend-down" (AS-D@) principle that permits the curing of the UB. "Spend-down" is a procedure whereby the provider spends 1) all available FDA funds at the time of the borrowing that were not contractually committed, and 2) the tainted funds resulting from the UB. In 1994, this policy was added to 42 C.F.R. ' 413.134(e)(2)(iii) which stated that a provider could remove [cure] the Aunnecessary@ characterization by using the funds for a proper purpose, i.e., capital related expenditures (ACRE@). This policy was initially set forth in a Blue Cross Association "Administrative Bulletin ("AB") 1186'[8] and has been cited in appealed cases.

In 1992, the HCFA Administrator explained the spenddown principle in the Rockford Memorial case as follows:

> Although not required by law ... HCFA has adopted spenddown as a matter of policy in regards to curing unnecessary borrowing.[9] Spenddown is a process whereby the agency permits a provider to "cure" borrowing that was unnecessary because of available funded depreciation by using those funded depreciation funds for proper purposes. . . Thus, as a matter of policy, the agency is willing to permit providers to cure an unnecessry borrowing by spending all available FDA funds and the tainted funds which resulted in the unnecessary borrowing.
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> Rockford Memorial Hospital v. Aetna Life Insurance Co., Medicare and Medicaid Guide, CCH, & 40,033 at pp. 34,475-76, Rem'd, HCFA Admr, November 23, 1992.

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[8] Provider Exhibit P-15, and Tr. at pp. 34 and 91-92.

[9] HCFA, noting that the spenddown policy has been applied consistently in implementing the Medicare program, adopted the spenddown principle by regulation at 42 C.F.R. ' 413.134(e)(3)(C). 56 Fed. Reg. 43358 at 43421 (1991). HCFA, consistent with that longstanding policy, requires that providers use the LIFO method of accounting to "cure" unnecessary borrowing.

PROVIDER'S CONTENTIONS:

The Provider=s representative stipulated at the hearing [Tr. P.44] that: 1) there would not be any challenge to the Intermediary=s determination that the $4 million borowing was unnecessary, and 2) the appeal would proceed challenging only the Intermediary=s S-D analysis and the UB curing theory.

The Provider=s broad scope contention was that the Intermediary did not properly apply the S-D [also referred to as draw-down ("D-D")]process in this case. This contention entails six concepts; namely, that the Intermediary:

1. Improperly characterized certain S-D transactions as administrative and general ("A&G") when, in fact, they were capital related in nature.

2. Assuming an A&G transaction [per 1.above], it was not properly treated as a S-D that would cure the UB.

3.Improperly characterized some S-D transactions as not properly linked to supporting documentation; and/or failed to identify some S-D transactions that occurred within one to two accounting cycles.

4. Did not recognize nor properly apply the Adelayed draw-down@ procedure.

5. Improperly made adjustments on the basis that the FDA was not properly maintained.

6. Failed to treat principal debt payments as capital related S-D.

7. In addition, The Provider asserts that some of the above Intermediary=s actions were impermissive because it was a matter of form over substance which constitutes arbitrary and capricious agency action; and these actions have resulted in an improper shifting of Medicare costs to private patients as prohibited by the Medicare statute at 42 U.S.C. ' 1395x(v)(1)(A).

I

The Provider states the Intermediary improperly characterized and treated some S-D transactions as A&G when, in fact, it was a capital related transaction.

The Provider asserts that Intermediary=s analysis of FDA transaction related to S-D of the $4 million UB are shown on Intermediary Exhibit I-1, pp 3 through 6. The key transactions are shown on p. 3 as follows:

Date	Explanation	A & G	CRE	Non-Allow	Total
	Suspended Funds				$4,000,000
11/86	Other Capital Additions	$146,014	$ 54,573		-200,587
12/86	Non-patient related WD			$267,424	-267,424
12/31/86	Balance	$ 146,014	$ 54,573	$267,424	$3,531,989
3/87	Self Ins fund	$ 1,847,400			- 1,847,400
4/87	Excess MP Cov.	1,262,039			- 1,262,039
5/87	Excess MP Cov.	255,464			- 255,464
12/31/87	Balance	$ 3,510,917	$ 54,573	$267,424	$ 167,086

For example, the Provider asserts the senior vice president and chief financial officer (ACFO@) issued a memo dated, February 26, 1987 [Intermediary Exhibit I-1, p. 14 & 15], after approval from the Board of Directors and the Finance Committee, approving the transfer of $1,933,209 from the FDA to the operating account (AO/A@).[10] The Provider asserts that although the second page of the memo stated the current disposition of these funds would be used for A&G purposes, this was in reality a capital related replenishment transaction. At the hearing, testimony showed this transfer represented reimbursement for CRE made from the O/A from October 1, 1984 to December 31, 1986. [Tr. p. 62]. The Provider states the memo referred to the CFO=s analysis per attachments thereto (which were not made part of the Intermediary=s Exhibit) that showed the capital purchases. [Tr. pp. 62 and 118]. Thus, the FDA was replenishing the O/A for prior capital purchases. The Provider claims this is also supported by minutes of the Provider=s Finance Committee.[11] The Provider claims the Intermediary improperly treated this transfer solely as A&G because 1) they only focused on the additional language on page 2 of the February 26th memo stating how the transferred funds would now be used, i.e., for A&G purposes: $1.8 million for malpractice self-insurance and $133,209 for the cash deficit; and 2) failed to properly consider the attachments referring to the CRE. The Provider >s witness testified this transaction essentially represented an offset of monies owed between funds located in different banks; so no accounting entries were made. If transfer transactions had been made between funds, the banks would have charged transaction fees. (Tr. pp. 63-68).

In addition, the Provider claims the other two transactions in 1987 were also CRE as explained in III below. Provider Exhibit P-4 shows CRE within a one to two month accounting cycle for these two transactions. Therefore, all three transactions in 1987 were capital related S-Ds. Moreover, there was no published HCFA policy regarding the treatment of these delayed draw-downs.

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[10] See Provider Exhibit P-13.

[11] Id. 9 at p-4.

The Provider cites as precedent for treating S-D on a capital basis the case of St. John=s Hospital and Health Center v. Blue Cross Ass=n, PRRB Decision 77-D56R, Sept. 29, 1978; [1979-1 Transfer Binder] Medicare and Medicaid Guide (CCH) & 29436. In that case, the Provider purchased capital assets using funds in the general operating account and then reimbursed the operating account from FDA. The PRRB held that this practice satisfied the FDA tracing requirements.

The Provider states the CFO had made a cash flow forecast on April 1, 1987 (Intermediary Exhibit I-1, pp. 19 to 22) showing planned expenditures which included: capital related purchases of about $3.9 million, bond debt retirement of $385,000, capital leases of $568,000 as well as other specific operating costs. The Provider claims the Intermediary=s auditors ignored specific information of these planned CRE, failed to request source documents of CRE, and treated an obvious replenishment transaction as A&G which was deemed improperly to be an invalid S-D. (See II below).

II

The Provider asserts UB can be cured on an A&G basis. The Provider disagrees with the Intermediary=s assertion that A&G S-Ds were not a bona fide cure for the UB. The Provider states the Intermediary=s representative testified at the hearing (Tr. pp 91-92) that Administrative Bulletin 1186 (AAB@)[Provider Exhibit P-15] represented HCFA policy regarding UB and the curing thereof, effective October 1977 which was in effect for FY 1988. The Provider asserts that AB 1186 cites an example where UB was cured on a working capital, or A&G, basis. (Provider Exhibit P-15, pp. 14-15, #8). The Provider=s witness testified that AB 1186 allows UB to be cured on an A&G basis; and the Intermediary=s witness also agreed on cross-examination. (Tr. Pp. 92 and 221 - 223). Therefore, the Provider claims UB can be cured with A&G S-D transactions.

The Provider also states the HCFA manual instructions at ' 226.1 permits borrowing from the FDA for A&G purposes. This section requires the assessment of interest on the loan, and then permits the interest expense assessed as an allowable cost. The provision increases program liability.

III

The Provider contends that the Intermediary improperly characterized some S-D as not being properly linked to supporting documentation; and/or failed to identify some S-D transactions as occuring within one to two accounting cycles.

The Provider asserts the Intermediary failed to advise it of the acceptable practice of identifying CRE within one to two accounting cycles either before or after the audit. The Provider=s witness testified this information only became known after the appeal was filed. (Tr. p. 82). Therefore, Provider Exhibit P-4 prepared for this appeal could have been created at the time of the audit if it had prior information of this procedure.

With respect to the three 1987 withdrawals from FDA, the Provider asserts that its Exhibit P-4 identifies CRE from January through July 1987 which would substantiate that the major portion of the withdrawals were CRE either by the replenishment process and/or the one to two accounting cycle method. The Provider asserts the data reported on Exhibit P-4 was supported by contemporaneous source documents that existed at the time of the audit; and disagrees with the Intermediary=s position that it was untimely prepared, i.e., made for the appeal rather than the audit. The Provider has submitted copies of the supporting source documents as part of Exhibit P-4 thereby evidencing an audit trail existed. The Provider=s witness traced a transaction from the Exhibit P-4 to the source documents. (Tr. pp. 75 to 77). The witness also testified that the Intermediary=s auditors did not request any source documents for CRE. (Tr. p. 82).

The Provider states that failure to recognize these transactions as proper S-D for CRE represents form over substance that constitutes arbitrary and capricious agency action resulting in an impremissible shifting of Medicare costs to other patients.

The Provider maintains the one to two accounting cycle method ignores certain realities that could extend the actual payment time from the D-D. For example, highly technical equipment may be installed with trial operations and the working out of problems; and/or problems develop within a few days after final installation requiring the vendor to perform additional work. In both situtations, payment would be delayed until all matters were resolved even though the D-D occured a month or two earlier in anticipation the installation would be uneventful.

The Provider disagrees with the Intermediary=s posiiton that valid FDA withdrawals must be tied specifically to asset acquisitions because this position is unrealistic, burdensome and not required by existing regulations or policy. The Provider asserts the replenishment process is more realistic. Moreover, the Provider asserts the HCFA witness has presented a concept that protects the Medicare program where the replenishment process is delayed, as discussed in IV below, which supports the replenishment process as an acceptable S-D method.

IV

The Provider contends the Intermediary failed to apply the ADelayed Draw-down@ (AD/D-D@) concept advocated by HCFA. [See, Provider Exhibit P-7, Attachment D]. This concept has been presented by HCFA staff at professional seminars for the past 3-4 years, e.g., at the annual AInstitute of Medicare and Medicaid Payment Issues@ seminar sponsored by the American Health Lawyers Association.

The Provider asserts that under the D/D-D procedure [which is a replenishment transaction] there should be an adjustment to investment income for only the lag time involved against otherwise allowable interest expense, i.e., compute the amount of lag time between the D-D and when the CRE were made to determine the amount of interest not available for sheltering.

The Provider maintains, however, there is no need for a corrective adjustment regarding the investment income earned by the suspended FDA funds (UB) during the delay. The Provider states the AB 1186 bulletin provides that the investment income earned by the UB funds was sheltered from the interest expense offset because the interest expense on UB have already been 100% disallowed. However, once the UB has been cured by S-D transactions, then the borrowing becomes necessary as of the date of the curing, and the interest expense incurred as of that date becomes allowable. Thus, in this case, there is no need for an adjustment regarding income earned during the delay.

V

The Provider disagrees with the Intermediary=s assertion that the FDA was not properly maintained; and that related adjustments were improper.

VI

The Provider contends the Intermediary failed to recognize principal bond debt payments as capital related S-D transactions.

VII

The Provider concludes that the Intermediary=s failure to properly treat all the S-D transactions as a bona fide curing of the UB results in a statutorily prohibited shifting of Medicare=s portion of the interest expense to private patients in violation of 42 U.S.C. ' 1395x(v)(1)(A).

INTERMEDIARY'S CONTENTIONS:

The Intermediary makes three broad contentions:

1. That $4 million of the 1985 bond indebtedness was unnecessary borrowing ("UB") because: a) in the Statement of "Fund Uses," the funds were not identified as being used for any capital acquisitions related to patient care; and b) the FDA had $3.1 million available[12] that was not contractually committed.

2. That after payment of $105,000 to the general fund for past bond costs, the remaining balance of the $4 UB ($3.895,000) was added to the FDA which was considered as an invalid FDA deposit since it was not identifiable with capital acquisitions; and the Provider failed to maintain the FDA in accordance with the manual provisions stated in HCFA Pub. 15-1 ' 226.5.

[12] Intermediary Exhibit 1 at 3.

3. That in tracking the disbursements from the FDA related to the $4 million UB, the S-D principle was not properly applied by the Provider. The Intermediary asserts: a) there was inadequate documentaion regarding capital purchases except for $54,573; and b) about $3.5 million was spent on administrative and general ("A&G") operating costs which was improper for S-D purposes.

The Intermediary also contends that additional adjustments are now required. For example, since there was $4 million in UB, then a portion of the ›Issuance costs=, $940,489, should also be disallowed. (Tr. p. 104).

I

The Intermediary contends that four million dollars of the 1985 bond issuance was unnecessary borrowing (AUB@) because there was no specific intended use of these funds for capital related purposes. No financial need was established. The AEstimated Source and Use of Funds@ for the bond proceeds identified $4 million for AReimbursement of Project Costs,@ but there was no documentaion concerning this item. There was no indebtedness to liquidate nor documentation of any assets already purchased. There was no evidence presented that the Provider had any plan of capital purchases. In addition, the FDA had an available balance of about $3.1 million not contractually committed. Therefore, there was no immediate capital related need for the $4 million.

[NOTE: At the hearing the Provider abandoned this issue.]

II

The Intermediary contends that the deposit of $3,895,000 [from the $4 million UB after paying $105,000 for past bond costs] in the FDA was an improper deposit. The amount was not identified with any intended capital related purchases. Since it was funds from UB, the FDA was not a proper placement of these funds. Thus, all interest income earned on the UB funds while in the FDA could not be sheltered under the regulations at 42 C.F.R. ' 413.134(e).

III

In 1988, the Intermediary asserts it determined from the progression schedule tracking FDA disbursements (Intermediary Exhibit I-1, pp. 3 to 6) the following S-D tabulation:[13]

[13] Intermediary Exhibit 7.

	$4 Million Interest Layer	Expense
Capital Related	$ 54,573	$ 5,018
Admin & General	3,510,917	322,835
Nonallowable costs	267,424	24,590
Suspended	167,086	15,364
Total	$4,000,000	$367,807

The Intermediary states that curing of the UB under S-D, requires an FDA withdrawal for an allowable capital related purpose, and that there must be an adequate audit trail.

The Intermediary maintains that even the $54,573 withdrawal for capital related purposes really should not be recognized as a proper S-D because there was a lack of documented connection between the time of the withdrawal and the individual assets purchased. Thus, there was an improper time linkage of withdrawals and purchases. The Intermediary claims this same problem persisted with other transactions at issue.

Intermediary asserts a sufficient audit trail must exist to warrant the benefits of S-D as the Fourth Circuit Court of Appeals stated in Pleasant Valley Hosp. v. Blue Cross and Blue Shield Assn., [1992-2 Transfer Binder] Medicare and Medicaid Guide (CCH) ¶40,903 (HCFA Admr, Oct. 19, 1992) (Tr. p. 250).

The Intermediary also referenced the Santa Maria Hosp.[14] case which 1) supports the audit trail requirement; and 2) permits an explanation of a transaction that may have multiple interpretations if there is a documented plan in advance of the event. (Tr. p. 247). In the present case, there were no FDA withdrawals specifically tied to any asset acquisition or group of acquisitions; nor any purchase transactions within a relatively short time frame, i.e., one or two months. (Tr. pp. 217-219, and 249).

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[14] St. Francis Community Hosp. v. Schweiker, [1984-2 Transfer Binder] Medicare and Medicaid Guide (CCH) ¶ 34,156 (D.C.S.C. No. 82-97-3, March 10, 1983).

Santa Maria Hosp. v. Blue Cross & Blue Shield Assn, [1992-1 Transfer Binder] Medicare and Medicaid Guide (CCH) ¶ 39,697 (PRRB Dec. No. 91-D81, Sept. 20, 1991).

St. Johns Hospital and Health Center v. Blue Cross Assn, PRRB Decision 77-D56R, Sept. 29, 1978; [1979-1 Transfer Binder] Medicare and Medicaid Guide (CCH) ¶ 29,436.

The Intermediary maintains that the Provider=s Exhibit P-4 does not properly support CRE either on a replenishment basis or within one to two accounting cycle. There is no linking of any specific asset purchases or group of purchases within a relatively short time frame. The Intermediary states that the preparation of this document for the appeal is not only too late, but it does not serve the purpose for which it was offered because there is no linkage of specific CRE. There are no D-D specifically identified to capital purchases. The Intermediary asserts Exhibit P-4 is a last minute attempt to show some CRE which does not support any acceptable S-D transactions.

The Intermediary also claims that the $3,510,917 withdrawals for A&G operating costs were not proper for S-D. (Tr. p. 221). These withdrawals were paid directly into a self-insurance account for malpractice insurance. The Intermediary states it can not accept the Provider=s assertion the March 1987 D-D was a replenishment because it is completely unsupported. This D-D (and the others in 1987) are obvious A&G transactions with no audit trail showing otherwise. The Intermediary asserts that to recharacterize the March 1987 D-D as a replenishment would have to be supported by a prior plan or specific linkage of CRE which is absent. The Intermediary disagrees with the Provider=s assertion that AB 1186 bulletin permits S-D on an A&G basis despite the example referenced therein, it just does not support the contention. AB 1186 bulletin has been in effect since October 1977 and has not been used to support A&G S-D as being proper.

CITATION OF LAW, REGULATIONS, AND PROGRAM INSTRUCTIONS:

1. Law - 42 U.S.C.:

- 1395x(v)(1)(A)et seq. - Reasonable Cost

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

- 405.1835-41 - Right to a Board Hearing
- 413.5 - Cost Reimbursement - General
- 413.9 et seq. - Cost Related to Patient Care
- 413.9(c)(2) - Cost Related to Patient Care. Application
- 413.20 - Financial Data and Reports
- 413.24 - Adequate Cost Data and Cost Finding

' 413.134 et seq.	-	Depreciation: Allowance for Depreciation based on Asset Costs
' 413.153 et seq.	-	Interest Expense

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

' 202.1	-	Interest
' 202.2	-	Necessary provision
' 226 et seq.	-	Funded Depreciation

Transmitted 279, January 1983, Medicare and Medicaid Guide (CCH) &5124.

4. Federal Register:

56 Fed. Reg. 43,358 (1991)

56 Fed. Reg. 43,421 (1991)

56 Fed. Reg. 43,456 (1991)

59 Fed. Reg. 45,401 (1994)

5. Cases:

Rockford Memorial Hospital v. Aetna Life Insurance Co., Medicare and Medicaid Guide, CCH, & 40,033 Rem'd, HCFA Admr, November 23, 1992.

Pleasant Valley Hosp. v. Blue Cross & Blue Shield Ass=n., [1992-2 Transfer Binder] Medicare and Medicaid Guide (CCH) & 40,903 (HCFA Adm=r, Oct. 19, 1992).

St. Francis Community Hosp. v. Schweiker, [1984-2 Transfer Binder] Medicare and Medicaid Guide (CCH) & 34,156 (D.C.S.C. No. 82-97-3, March 10, 1983).

Santa Maria Hosp. v. Blue Cross & Blue Shield Ass=n, [1992-1 Transfer Binder] Medicare and Medicaid Guide (CCH) & 39,697 (PRRB Dec. No. 91-D81, Sept. 20, 1991).

St. John=s Hospital and Health Center v. Blue Cross Ass=n, PRRB Decision 77-D56R, Sept. 29, 1978; [1979-1 Transfer Binder] Medicare and Medicaid Guide (CCH) & 29,436.

6. Other:

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FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board, after consideration of the facts, parties= contentions, and evidence presented, testimony at the hearing, and post-hearing briefs, finds and concludes that the Provider has submitted substantial evidence in support of its position that a portion of the unnecessary borrowing had been properly cured under the Medicare "spend-down" ("S-D") procedure.
The Intermediary=s adjustment is modified to recognize the proper S-D of $1,097,101 as supported by the Provider=s Exhibit P-4.

The Board makes the following findings:

1. That the Provider abandoned its challenge to the Intermediary=s determination that there was $4 million dollars of unnecessary borrowing ("UB") in 1985. Therefore, the UB aspect is not an issue; and the appeal is concerned solely with the propriety of the Intermediary=s S-D analysis, i.e., was all or a portion of the UB properly cured for the 1988 cost year.

2. That the controlling regulations concerning: a) interest expense is 42 C.F.R. '413.153 which governs its allowability, sheltering of interest income earned on funded depreciation accounts ("FDA"), etc.; and b) the funding of depreciation is 42 C.F.R. '413.134(e).

3. a) That in 1988, 42 C.F.R. '413.134(e) was very limited in scope. It only recommended the funding of depreciation and did not provide any requirements for the maintenance of the FDA or limitations thereon. As an incentive for funding, the investment income earned on the FDA would not be treated as a reduction of allowable interest expense.

b) That the scope of 42 C.F.R. '413.134(e) was greatly expanded from 1991 to 1994.

4. That the Provider Reimbursement Manual, HCFA Pub. '226, did provide some guidance regarding the FDA.

5. That Medicare had adopted the S-D principle for curing UB as evidenced by HCFA Administrator and Board Decisions, such as the Rockford case.

6. That based on the evidence and testimony at the hearing, a shadow was cast on the credibility of the capital audit resulting in the adjustments under appeal. For example:

a) the Intermediary apparently imposed an unsupported requirement of linking capital expenditures with S-D within 1-2 accounting periods (months) which had never been communicated to the Provider or otherwise documented in 1988. (Tr. p. 82).

b) at the time of the audit, the auditors did not pursue documentation available and relevant to capital expenditures, e.g., the documentation relevant to the Provider=s Exhibit P-4 was not sought or examined even though offered. (Tr. p. 82).

c) with respect to Intermediary Exhibit I-1, pp. 14-15, the auditors did not pursue referenced documents on p. 14 that clearly showed the authorization of $1.9 being transferred from FDA to the general account was a replenishment transaction for prior capital expenditures. Instead, the auditors relied upon the statements on p. 15 that the use of the FDA funds were now for administrative and general (AA&G@) purposes. Thus, the auditors concluded this was an improper S-D transaction in making their determination. (Intermediary Exhibit I-1, pp 14-15; Tr. pp. 65 and 82). Hence, item c) for $1.9 million could have been a proper S-D transaction if properly examined, but the record as created is insufficient to make that determination.

7. That the Provider=s basic structure and application of the S-D procedure was reasonable.

8. That the Intermediary properly determined $54,573 had been S-D for capital purposes. However, the determination that $3,510,917 had been spent for A&G purposes was incorrect.

9. a) That the Provider met its burden by, testimony at the hearing and evidence presented, demonstrating that a portion of the UB was properly cured by applying the S-D procedure in the amount of $1,097,101 pursuant to the Provider=s Exhibit P-4. This extensive and comprehensive exhibit consisted of a summary schedule supported by purchase documentation demonstrating a reasonable linkage of capital expenditures to the FDA withdrawls as a proper S-D.

b) Although this exhibit was prepared for the hearing, the purchase documentation provided adequate and sufficient documentation of contemporaneous records that were readily available at the time of the Intermediary=s capital expenditure audit. The Provider=s witness testified this documentation was offered but declined by the auditors (Tr. p. 82); and the Intermediary=s witness testified that had it been examined, it would have been an acceptable S-D. (Tr. p. 229).

c) The production of documents subsequent to an audit is permissible because: 1) the purpose of a hearing is to determine whether adequate documentation existed with respect to the issue and the claim for allowable expenses; and 2) the Provider did not create new records, in that the exhibit summarized and produced the documentation maintained and available for audit during the fiscal year at issue. These records were maintained and verifiable as required by the regulations at 42 C.F.R. '' 413.20 and 413.24.

The Board concludes that the Intermediary=s adjustment must be modified to include a proper S-D of another $1,097,101 with appropriate related adjustments.

DECISION AND ORDER:

The Intermediary=s analysis and application of the Medicare spend down procedure concerning the curing of the $4 million unnecessary borrowing was improper. The Intermediary=s adjustments must be modified and recalculated to include an additional amount of $1,097,101 as properly cured under the spend down procedure.

BOARD MEMBERS PARTICIPATING:

Irvin W. Kues
Henry C. Wessman, Esquire
Martin W. Hoover, Jr., Esquire
Charles R. Barker
Stanley J. Sokolove

Date of Decision: January 17, 2001

FOR THE BOARD:

Irvin W. Kues
Chairman