PROVIDER REIMBURSEMENT REVIEW BOARD
HEARING DECISION

2002-D43

PROVIDER –
Southern Indiana Rehabilitation Hospital
New Albany, Indiana

Provider No. 15-2009

vs.

INTERMEDIARY –
Blue Cross and Blue Shield Association
AdminaStar Federal Inc.

DATE OF HEARING-
March 18, 2002

Cost Reporting Periods Ended
February 28, 1995
February 29, 1996

CASE NO. 98-2295, 99-2144

INDEX

ISSUES:

1. Was the Intermediary's determination of the provider's Medicare TEFRA base year proper?

2. Was the Intermediary's determination of the Provider's TEFRA target rate limitation proper?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Southern Indiana Rehabilitation Hospital ("SIR-H") is a joint venture formed by Frazier Rehabilitation Hospital, Clark Memorial Hospital, and Floyd Memorial Hospital. By correspondence dated August 3, 1993, Charles Booth, Director of the Office of Payment Policy - Bureau of Policy Development of the Health Care Financing Administration, determined that the formation of SIR-H would not be considered a new provider under 42 C.F.R. § 413.30, thus permitting an exception from payment limits, but would constitute a reorganization of an existing rehab unit as a freestanding hospital.[1]

The hospital was certified as a rehabilitation hospital with a provider number 15-3031 and an effective Medicare participation date of March 11, 1994.[2] SIR-H operated as a rehabilitation hospital for approximately seven months. In September of 1994, SIR-H filed a request with the Health Care Financing Administration ("HCFA") to change its classification to a long-term care hospital.[3] HCFA approved the conversion to a long-term care hospital, and issued a Tie-In Notice with an effective date of October 1, 1994 for the new provider number 15-2009.[4]

The Intermediary notified the Provider that it would need to file two cost reports covering the first year of operation. One cost report would cover provider number 15-3031 for the period March 11,1994 to its termination of participation on September 30, 1994. A second cost report for provider number 15-2009 would cover the period from October 1, 1994 to February 28, 1995.[5] The terminating cost report for provider number 15-3031 is required under HCFA Pub. 15-1, Section 2414.2(A) which states:

> Final Cost Report. - When a provider ceases to participate in the health insurance program, it must file a cost report covering a period under the program up to the effective date of cessation

[1] See Provider's post-hearing brief Exhibit P-1.
[2] See Intermediary's position paper Exhibit I-1.
[3] See Trans. P.66.
[4] See Intermediary's position paper Exhibit I-3
[5] See Provider's position paper P-12.

of participation in the program.

HCFA Pub. 15-1 § 2414.2(A)

Because the rehabilitation hospital, provider number 15-3031 ceased to participate in the Medicare program on September 30, 1994, a final terminating cost report covering the short seven month period was required.

The Provider filed three cost reports, the two outlined in the Intermediary letter at Exhibit P-12 of the Provider's position paper, and a consolidated cost report covering the entire period from March 1, 1994 to February 28, 1995 which combined the data from the two short cost reports. Based on the consolidated cost report, the Provider claimed its TEFRA base year should be the 12-month period from March 1, 1994 to February 28, 1995.

The parties have stipulated on the record that there are no certification issues and that the focus of the appeal is based on the filing of the two (2) short cost reports.[6] Although the record contains two issues, the Board has combined the issues into one to be consistent with the parties post-hearing briefs.

The Provider's filing meets the jurisdictional requirements of 42 C.F.R. 405.1835-.1841. The Provider was represented by Todd Selby, Esquire, of Hall, Render, Killian, Heath & Lyman, P.S.C. The Intermediary was represented by James R. Grimes, Esquire, Associate Counsel, Blue Cross and Blue Shield Association on behalf of AdminaStar Federal Inc., ("the Intermediary").

PROVIDER'S CONTENTIONS:

The Provider contends that March 1, 1994, to February 28, 1995 should be its base year. The Provider believes this is the case due to the following facts. First and foremost, March 1, 1994 to February 28, 1995 should be its base year as it has been stipulated by the parties at the hearing that the certification date is no longer an issue. The fact that Provider's certification date is no longer an issue is contrary to what the Provider was led to believe in the eight (8) years leading to the PRRB hearing. The Provider was led to believe, based on numerous meetings and discussions with the Intermediary, that the first full year of operations would be its base year.[7] The Provider admitted its first patient prior to March 1, 1994. Therefore, the Provider's first full year of operations should have been classified as its base year. The Provider also contends that the Intermediary believed March 1, 1994 to February 28, 1995 was to be its base year since the initial and subsequent NPRs received from the Intermediary indicated such.

[6] See Trans at 96.

[7] See Provider's post-hearing brief Exhibit P-3.

The Provider insists the Intermediary has stipulated that the March 11, 1994 certification date had no impact on the Intermediary's base year determination. However, now, nearly eight (8) years after the Provider began discussions with the Intermediary, the Intermediary has reversed its position as to why March 1, 1994 to February 28, 1995 could not be used to establish the Provider's base year. The Intermediary now states that March 1, 1994 to February 28, 1995 could not be used as its base year because of the Provider's conversion from a PPS-excluded rehabilitation hospital to a PPS-excluded long-term care hospital, thus necessitating the filing of two (2) short cost reports. This is contrary to the understanding the Provider had with the Intermediary.

After determining the level of rehabilitation care delivered to its patients was medically complex, involving lengths of stay in excess of twenty-five (25) days, the Provider believed it would be prudent to convert its operations to a PPS-excluded rehabilitation long-term care hospital.[8] This request was made to HCFA on September 14, 1994. On February 6, 1995[9], HCFA notified the Provider that it was approving its long-term care hospital, assigning provider number 15-2009, effective October 1, 1994.[10]

As the Provider's witness testified, the request to participate as a PPS-excluded long term care hospital necessitated the Provider to file two (2) short cost reports in its first year of operation: (1) a cost report for the PPS-excluded hospital provider number 15-3031 from March 1, 1994 to September 30, 1994; and (2) a second cost report that was required for the conversion to the PPS-excluded long-term care hospital provider number 15-2009 from October 1, 1994 to February 28, 1995.[11] The Provider's witness testified that in discussions with the Intermediary he was instructed that these cost reports were merely for administrative reasons and that the filing of the two (2) cost reports would have no impact on the Provider's base year determination.[12] The Provider filed what was deemed to be the official cost report for the full year of operations of March 1, 1994 to February 28, 1995.[13] This was the cost report for which the Provider's NPR was issued and correlated with the Intermediary's advice that the base year would be the first full year of operations.[14] This was also confirmed in the letter dated June 29, 1995 from the Provider to the Intermediary.[15]

As stated by the Intermediary's witness at the hearing and in its Position Paper, the conversion of the Provider to a PPS-excluded long term care hospital and the filing of two (2) cost reports prevented the Provider from establishing March 1, 1994 to

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[8] See Trans at 49 and 50.
[9] See Provider's position paper, Exhibit P-15.
[10] See Provider's position paper, Exhibit P-8.
[11] See Trans at 73 and 74.
[12] See Trans at 72 and 73.
[13] See Trans at 72
[14] See Trans at 86.
[15] See Provider's post-hearing brief at Exhibit P-4.

February 28, 1995 as its base year. In its Position Paper, the Intermediary relied on 42 C.F.R. § 413.40(b)(1)(iii) as its authority. In reliance on this section of the federal regulations, the Intermediary stated in its Position Paper that "...the base period for the hospital or unit that changed its operational structure is the first cost reporting period of at least twelve (12) months effective with the revised Medicare certification reclassification." This is clearly contrary to the Provider's numerous communications with the Intermediary concerning its conversion to a PPS-excluded long-term care hospital. Additionally, the Provider contends that the Intermediary's reliance on 42 C.F.R. § 413.40(b)(1)(iii) is erroneous.

Apparently, the Intermediary continues to disregard the letter it sent to the Provider on May 31, 1995, where it was stated that the two (2) cost reports would have no bearing on the Provider's base year.[16] As stated above, the Provider was not notified it had been approved to participate as a PPS-excluded long-term care hospital until February 6, 1995, retroactive to October 1, 1994. The Provider was unaware that it had been approved as a PPS-excluded long term care hospital, as it continued to bill under its PPS-excluded rehabilitation hospital provider number 15-3031 for a period of time until it ultimately received approval as a PPS-excluded long-term care hospital. Although the Intermediary requested the Provider to file two (2) cost reports, it specifically stated: "Our requirement for two (2) cost reports will not change the normal base year determination."[17]

In her testimony, the Intermediary's witness stated she believed the advice previously given to the Provider that the base year should have been the first full year of operations was incorrect. The Intermediary's witness believed that they provided advice of what the base year would have been had the Provider been classified as a new hospital rather than a reorganization.[18] The plain fact of the matter, however, is that the Provider did clarify the advice the Intermediary provided in the letter of May 31, 1995.

The Provider asserts that, when it converted its operations from a PPS-excluded rehabilitation hospital to a PPS-excluded long term care hospital, it had no bearing on 42 C.F.R. § 413.40(b)(1)(iii), as it did not result in a "certification reclassification" as stated by the Intermediary in its Position Paper. Rehabilitation hospitals and long-term care hospitals are both excluded from the prospective payment system and are, thus, classified as PPS-excluded hospitals. Both rehabilitation hospitals and long-term care hospitals provide rehabilitation services. The only difference between a rehabilitation hospital and a long-term care hospital is that a rehabilitation hospital must treat at least 75% of its patients within certain diagnostic categories, while a long term care hospital must have an average length of stay of twenty-five (25) days.[19] The Provider's witness testified that the decision to convert to a PPS-excluded

[16] See Provider's post-hearing brief Exhibit P-3.
[17] See Trans at 72.
[18] See Trans at 168 and 169.
[19] See Trans at 59 and 60

long-term care hospital was due to treating a high number of pulmonary rehabilitation patients who did not fall within the diagnostic categories for a rehabilitation hospital.[20] Nothing prevents a PPS-excluded long-term care hospital from providing rehabilitation services. Therefore, but for the twenty-five (25) day average length of stay requirement, the Provider was offering the same classification of services to its patients in both the PPS-excluded rehabilitation hospital and the PPS-excluded long-term care hospital.

Once the Provider learned it would be a reorganization and not a new provider, it confirmed with the Intermediary that its base year would begin on March 1, 1994 regardless of the fact it converted from a rehabilitation hospital to a long term care hospital. More than four (4) years later, the Intermediary informed the Provider its base year would be from March 1, 1995 to February 29,1996, based on the fact that the Provider was not certified until March 11, 1994. Then, nearly another three (3) years later, the Intermediary, in its Position Paper, states the base year must be March 1, 1995 due to its filing of two (2) cost reports associated with its conversion from a rehabilitation hospital to a long-term care hospital. The Provider believes that the Intermediary has misinterpreted the intent of 42 C.F.R. § 413.40(b)(1)(iii).

The Provider notes that in the June 4, 1992 *Federal Register* at page 23660, HCFA issued proposed regulations concerning whether a hospital undergoing a reorganization should be recognized as a new hospital if it continues to provide the same classification of services before and after the reorganization. Because a reorganized hospital would not incur all of the start-up costs of a new hospital, HCFA believed the regulations should be revised to prevent reorganized hospitals from achieving new hospital status. The proposed regulations prohibited a reorganized hospital from achieving new hospital status, which allowed for an exemption from the rate-of-increase ceiling. In discussing the proposed rule, HCFA stated it wished to clarify 42 C.F.R. § 413.40(b)(1) to clearly indicate the "base period would be the first full 12-month cost reporting period effective with the revised Medicare certification."

The rules regarding the base year for reorganized entities became final as published in the September 1, 1992 *Federal Register* at page 39802. In the comment to the final rules dealing with reorganized providers, HCFA reiterated the comment set forth above from the proposed rules with one slight but significant variance. In its clarification of 42 C.F.R. § 413.40(b)(1), HCFA stated the “base period would be the first full 12-month cost reporting period effective with the revised Medicare certification classification.” In addition to the Provider being told by both HCFA and the Intermediary that its base year would be its first full year of operations, the Provider believes the addition of the word “classification” in the final regulations allows it to utilize March 1, 1994 to February 28, 1995 as its base year.

It is obvious the Intermediary interpreted 42 C.F.R. § 413.40(b)(1)(iii) as stated in the proposed rule, where the base year would be tied to a provider’s “Medicare

[20] See Trans at 50.

certification." This belief stems from the fact that the Intermediary, in its Position Paper, felt that the conversion from a rehabilitation hospital to a long-term care hospital and the filing of the two (2) short unofficial cost reports changed the Provider's base year determination. The Provider believes the Intermediary's reliance on the language found in the proposed rule is in error.

If the Intermediary would have literally interpreted 42 C.F.R. § 413.40(b)(1)(iii) as set forth in the final rule, the Provider believes it should be allowed to establish March 1, 1994 as the start of its base year. The Provider's belief is founded in the fact that its "Medicare classification" did not change. Prior to the reorganization, both Clark's unit and Frazier provided Medicare approved PPS-excluded rehabilitation services and had existing Medicare provider agreements. After the Provider was established, it provided PPS-excluded rehabilitation services. Therefore, there was no "revised Medicare classification" because the Provider had always provided PPS-excluded rehabilitation services. In fact, this was the sole basis for HCFA's conclusion that the Provider was not a new provider but rather a reorganization, because the Provider continued to provide the same services before and after the reorganization. Since the Provider's "Medicare classification" did not change, its first full cost reporting period would have been March 1, 1994 to February 28, 1995.

The Provider contends that if HCFA had intended another result, it could have easily adopted the standard set forth in 42 C.F.R. § 413.40(b)(1)(ii), where it discusses the base year for PPS-excluded units. This section of the federal regulations states that a PPS-excluded unit's base period is a "...period of at least 12 months following the unit's certification to participate in the Medicare program." This regulation is explicit in stating a "unit" cannot establish its base year until one year after "the unit's certification to participate in the Medicare program." If a similar result were intended for reorganizations, HCFA could have merely replaced the words "certification classification" with "certification to participate in the Medicare program. "The reason HCFA did not adopt similar language for reorganizations is simple. Reorganizations involve the same classification of services and usually only require a relocation of the provider services which, for the Provider, happens to be PPS-excluded rehabilitation services.

Based on the above set of circumstances and advice that the Provider received and confirmed in writing with the Intermediary, the Provider believes it complied with 42 C.F.R. § 413.40(b)(1). Since the Provider filed only one official cost report for the period of March 1, 1994 to February 28, 1995, it complied with the provision of 42 C.F.R. § 413.40(b)(1). Therefore, the Provider's cost reporting period was "...at least 12 months immediately preceding the first cost reporting period…." pursuant to 42 C.F.R. § 413.40(b)(1). This is even more evident by the fact that the Provider's NPR was based on a March 1, 1994 to February 28, 1995 cost reporting period.

The Provider claims that if the Intermediary produces NPRs for the two (2) short cost reports, as requested by the PRRB at the hearing,[21] there would still be no change in the certification classification of Provider. For the short unofficial cost reporting period as a rehabilitation hospital, the Provider delivered a classification of rehabilitation services to at least 75% of its patients falling within certain diagnostic categories. For the short unofficial cost report as a long-term care hospital, the Provider delivered a classification of rehabilitation services to patients with an average length of stay of twenty-five (25) days. Quite simply, the "classification" of services did not change. Since the Provider delivered a classification of rehabilitation services regardless of whether NPRs were issued for the short unofficial cost reports, the Provider should be allowed to maintain March 1, 1994 to February 28, 1995 as its base period.

There was no reimbursement impact with the Provider's conversion from a rehabilitation hospital to a long-term care hospital as both were PPS-excluded hospitals. The testimony of the Provider's witnesses and that of the Intermediary's witness confirmed this to be the case. If there was no change in reimbursement as a result of the conversion, the Provider's base year should have been March 1, 1994 to February 28, 1995.

Surprisingly, the Intermediary's witness, while stating that the Provider should not be allowed to have a base year of March 1, 1994 to February 28, 1995, agrees there would have been no reimbursement impact from the Provider converting from a rehabilitation hospital to a long-term care hospital. In redirect examination by her counsel, the witness stated on the record that "...revenues and costs should not have changed between the certifications, and the Medicare data would have only been reflected for the long-term-care facility."[22] Again, in redirect examination, the witness stated "...you should see very little, if any, change in the reimbursement for the NPR" as a result of the conversion from a rehabilitation hospital to a long term care hospital.[23]

In conclusion, the Provider states that if the operations did not change, the reimbursement did not change. The Provider was issued only one NPR from March 1, 1994 to February 28, 1995. It is difficult to see any rational basis as to why the base year would not have been March 1, 1994 to February 28, 1995.

INTERMEDIARY'S CONTENTIONS:

The Intermediary determined that the base year for the SIR-H, provider number 15-2009 is the 12-month cost reporting period from March 1, 1995 to February 28, 1996.

[21] See Trans at 195
[22] See Trans at 187.
[23] See Trans at 187.

The base period for the provider is determined by reference to 42 C.F.R. § 413.40 (b)(1):

> *Cost reporting periods subject to the rate-of-increase ceiling.* Each hospital's target amount is based on its allowable net inpatient operating costs per case from the cost reporting period of at least 12 months immediately preceding the first cost reporting period subject to the rate-of-increase ceiling established under this section. If the immediately preceding cost reporting period is a short reporting period (fewer than 12 months), the first period of at least 12 months subsequent to that short period is the base period.

42 C.F.R. § 413.40(b)(1)

In this case, SIR-H did not participate continuously as a long-term care hospital from its certification in March of 1994 to the end of the first 12-month period. Instead, SIR-H participated as a rehabilitation hospital for a seven-month period between March 11, 1994 and September 30, 1994 under provider number 15-3031. Thereafter, SIR-H participated as a long-term care hospital for a five-month period from October 1, 1994 to February 28, 1995, under provider number 15-2009. Each provider then had a short reporting period. Applying the requirements of 42 C.F.R. § 413.40(b)(1), because the immediately preceding cost reporting period for the long-term care provider was a short reporting period of five months, the first period of at least 12 months subsequent to the short reporting period would be the base period for the hospital. That 12-month period would begin on March 1, 1995 and end on February 28, 1996. The regulation is absolutely clear on the correct base period under the facts in this case and should be applied to this Provider.

The Intermediary contends that the Provider has pointed to inconsistent or even incorrect advice given by HCFA Region V representatives as well as representatives of the Intermediary. In the Intermediary's opinion, it is not clear whether some of the advice was the result of incorrect or incomplete information being given to the Intermediary. For example, the Intermediary witness pointed out that while the Intermediary letter at Exhibit P-12 indicated that the requirement of two cost reports covering the short reporting periods for the rehab and long-term care provider numbers would not change the normal base year determination, the writer of the letter was basing his advice on the premise that the hospital qualified as a new provider entitled to a new provider exemption in determining the base year.[24] Similarly, the Intermediary witness testified that other Intermediary employees involved in giving advice to the Provider were not aware at the time they were giving that advice, that the Provider had converted to long-term care hospital status after the first seven

[24] See Trans at 168).

months of operation.[25] The facts in this case kept changing, both before operations began at SIR-H, as well as after initial certification. To the extent the facts were not always clear or not fully explained, misinformation and mistaken advice could very well have been conveyed to the Provider. Nonetheless, the requirements of the regulation are clear. The Provider had it's own consultants and advisors reviewing the regulations and program instructions. It is the Intermediary's position that the Provider could determine on its own what the effect of the conversion to long-term care hospital status meant in connection to the base year determination.

The Intermediary asserts that Provider argues the language in 42 C.F.R. § 413.30(b)(1)(iii) should be determinative of this case. That section indicates that when the operational structure of a hospital or unit changes (freestanding or excluded unit), the base period is the first cost reporting period of at least 12 months effective with the revised Medicare certification classification. However, the Intermediary argues that this section is merely referring to a change in classification as a freestanding versus hospital-based unit, and not to its classification as a rehabilitation hospital or long-term care hospital. It is the classification of the hospital as a long-term care hospital that is significant for purposes of determining the correct base period in this case. 42 C.F.R. § 413.30(b)(1)(iii) would have been applicable if the hospital had not converted from a rehabilitation hospital (provider number 15-3031) to a long-term care hospital (provider number 15-2009) during the cost reporting year. However, because of actions taken by the Provider after the initial certification, the provisions at 42 C.F.R. § 413.40(b)(1) apply and the requirement of a full 12 month period for long-term hospital provider number 15-2009 is necessary for the base year.

The Intermediary notes that it incorrectly used the February 28, 1995 Cost Report for the purpose of settling the short reporting year ending on February 28, 1995 for Provider 15-2009. The Board asked the Intermediary whether the settlement of the single twelve-month cost report would produce a different result from the settlement of the two short cost reports. The Intermediary cannot locate a copy of the Provider's as filed cost report for October 1, 1994 through February 28, 1995. In order to consider whether or not the use of a twelve month cost report (as opposed to a five month cost report) for the long-term care provider would produce a different reimbursement effect, the Intermediary utilized schedules submitted by the Provider to adjust total expenses, revenues and statistics to reflect the five month period. (Intermediary Exhibit I-C). The Intermediary then revised the Settled Cost Report at Intermediary Exhibit I-B, reflecting the information in Intermediary Exhibit I-C, and where amounts were not identified, applied percentages identified in the schedules to determine the short period amounts. The Intermediary was then able to produce a short period cost report for the long-term care provider. (Intermediary Exhibit I-D). The Intermediary determined that the total net effect between the twelve-month cost report and the five-month cost report is $1,755.00.[26]

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[25] See Trans.at.170-71.

[26] See Intermediary's post-hearing brief Exhibit I-E.

However, while the total expenses, revenues, and statistics may reflect twelve months in the as filed cost report, the Medicare settlement data used for settlement of that cost report only reflected the five-month period from October 1, 1994 to February 28, 1995. In this way, total expenses, revenues and statistics were adjusted to match the PS&R, which only contained five months of patient day statistics and charges. The settled cost report was adjusted to match the cost to the PS&R settlement data using the schedules at Intermediary Exhibit I-C. As a result, the February 28, 1995 cost report was not settled as a 12 month cost report and cannot be used as a 12 month base year.

The Intermediary claims that the use of the twelve month cost report for settlement purposes did not produce a significantly different result than would have been the case had the Intermediary used the short cost report for provider 15-2009. However, the fact that reimbursement was not affected by the change of classification of the hospital, does not change the fact that the regulation clearly requires the use of a single twelve-month period preceding the period in which the rate of increase ceiling is to be applied. The regulation still requires that in the case of a short reporting period, the next full twelve month period is the TEFRA base period. 42 C.F.R. § 413.40(b)(1). The regulation does not make any exception in cases where provider classification changes do not have a significant impact on reimbursement. It merely states that if the immediately preceding reporting period is a short period of less than twelve months, then the first period of at least twelve months subsequent to that short period is the base period. In this case, the first reporting period for long term care provider number 15-2009 is a five month period ending February 28, 1995. Since that is a period of less than twelve full months, the subsequent period from March1, 1995 to February 28, 1996 is the base period under 42 C.F.R. § 413.40(b)(1).

CITATION OF LAW, REGULATIONS AND PROGRAM INSTRUCTIONS:

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

§§ 405.1835-.1841	-	Board Jurisdiction
§ 413.40 et. seq	-	Ceiling on the Rate of Increase in Hospital Inpatient Costs.
§ 413.30 et seq.	-	Limitation on Reimbursable Costs

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

§ 2414.2 et seq.	-	Cessation of Participation in

Program

§ 3003.6 (C)(1) - Changes in Organizational Structure

3. Other:

57 Fed. Reg. at 23660 (June 4, 1992)

57 Fed. Reg. at 39802 (September 1, 1992)

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

After consideration and analysis of the controlling law, regulations and manual guidelines, the facts of the case, parties' contentions, evidence presented and post-hearing briefs, the Board finds and concludes as follows:

ISSUE 1: TEFRA Base Year Determination

The Board finds that the hospital was certified as a rehabilitation hospital under provider number 15-3031 with an effective participation date of March 1, 1994.[27] The Provider operated as a rehabilitation hospital for approximately seven months.[28] In September of 1994, the facility filed a request with the Health Care Financing Administration ("HCFA") to change its operations to a long-term care hospital.[29] HCFA approved the conversion to a long-term care hospital and issued a Tie-In Notice with an effective date of October 1, 1994 for the new provider number 15-2009.[30] The Board finds that, when the Provider reorganized its facility from a rehabilitation hospital to a long-term care hospital, it was required to file two short period cost reports, as this conversion created a new provider number and the termination of another existing provider number.

The Board notes that there was voluminous correspondence in the record, from both parties, that caused uncertainty as to what the correct base year would be. The Board also recognizes that the Provider attempted numerous times to contact the Intermediary with hopes of determining that the base year would be FYE February 28, 1995. However, in a letter dated May 31, 1995,[31] the Intermediary informed the Provider that the base year would be "the first 12 month cost reporting period that begins at least 1 year after the hospital accepts its first patient," in accordance with HCFA Pub. 15-1, Section 3003.6 (C)(1). Based on the documentation in the record,

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[27] See Intermediary's position paper Exhibit I-1.

[28] Rehabilitation Hospital cost reporting period was 03/01/94-09/30/94.

[29] See Trans. P.66.

[30] See Intermediary's position paper Exhibit I-3 and Long-Term Care Hospital cost reporting period was 10/01/94-02/28/95.

[31] See Provider's post-hearing brief Exhibit P-3.

the Provider's first patient was seen in February, 1994. Therefore, the Board finds that the base year would be March 1, 1995 through February 28, 1996, since that was the Provider's first 12 month cost reporting period. The Board finds the May 31, 1995, letter from the Intermediary to be the most definitive evidence in the record of what advice the Intermediary gave regarding the appropriate base year.

The Board finds 42 C.F.R. 413.40 (b)(1) to be relevant and applicable in this case. It states:

> *Cost reporting periods subject to the rate-of-increase ceiling.* Each hospital's target amount is based on its allowable net inpatient operating costs per case from the cost reporting period of at least 12 months immediately preceding the first cost reporting period subject to the rate-of-increase ceiling established under this section. If the immediately preceding cost reporting period is a short reporting period (fewer than 12 months), the first period of at least 12 months subsequent to that short period is the base period.

42 C.F.R. § 413.40(b)(1).

Based on this regulation, the Board interprets the Provider's base year to be FYE February 28, 1996, since March 1, 1995 to February 28, 1996 was the Provider's first 12 month cost reporting period. HCFA issued two Tie-In Notices for two separate Providers; one for the termination of the rehabilitation hospital (7 months, 05-3031) and one for the creation of the long-term care hospital (5 months, 15-2009), which meant the Provider was responsible for filing two short period cost reports. Given the fact that these cost reports were for short periods, the Board concludes that they could not be used for the Provider's TEFRA base year, in accordance with the above mentioned Medicare regulations and manual instructions.

ISSUE 2: TEFRA Target Rate

The Board finds no arguments for the Provider that disputed the Intermediary's calculation of the TEFRA target rate. Therefore, the Board upholds the Intermediary's original adjustment.

DECISION AND ORDER:

ISSUE 1:

The Intermediary's determination assigning FYE February 28, 1996 as the Provider's TEFRA base year was correct. The Intermediary's determination is affirmed.

ISSUE 2:

The Intermediary's determination regarding the TEFRA target rate was correct. The Intermediary's determination is affirmed.

BOARD MEMBERS PARTICIPATING:

Irvin W. Kues
Henry C. Wessman, Esquire
Stanley J. Sokolove
Gary Blodgett, D.D.S.
Suzanne Cochran, Esquire

Date of Decision: September 26, 2002

FOR THE BOARD

Irvin W. Kues
Chairman