PROVIDER REIMBURSEMENT REVIEW BOARD
HEARING DECISION

ON-THE-RECORD
2003-D1

PROVIDER –
Skaggs Community Health Center
Branson Missouri

Provider No. 26-0094

vs.

INTERMEDIARY –
Mutual of Omaha Insurance Company

DATE OF HEARING -
September 11, 2002

Cost Reporting Periods Ended
April 30, 1996
April 30, 1997

CASE NOs. 99-0299
99-3610

INDEX

ISSUE:

Were the Intermediary's adjustments reclassifying home health agency (HHA) building rent to the HHA cost center and the elimination of corresponding square footage allocation statistics proper?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Skaggs Community Health Center (Provider) is a Medicare certified, 84-bed community hospital with a hospital-based skilled nursing facility (SNF) and a hospital-based HHA, located in Branson, Missouri.

The Provider appealed two cost reporting periods fiscal year ended (FYE) April 30, 1996 & FYE April 30, 1997), which have been combined into one Provider Reimbursement Review Board (Board) decision since the issue concerning the years in question is identical.

The Provider's HHA, Provider No. 26-0094, occupies space in three different buildings. One space consists of 3,500 square feet and is located in one of two hospital buildings, which comprise the Health Center's campus. The HHA also leases space in Kimberling City and Forsyth, Missouri from an unrelated party. In FYE April 30, 1996 the total square footage for the leased satellite offices was 6,500; in FYE April 30, 1997 it was 5,173.

Mutual of Omaha (Intermediary) audited the Provider's Medicare cost report and noted that the Provider allocated total rental expense of $50,570 for FYE April 30, 1996 and $42,790 for FYE April 30, 1997 for the two satellite offices to the HHA cost center. The Provider reported the rental expense in the Capital Related Building cost center of the Medicare cost report. Furthermore, for the years in question, the Provider included the square footage attributable to the two satellite offices in the total square footage statistics reported on Line 71, Administrative & General ("A& G") - HHA, of Worksheet B-1, which is the basis used for allocating certain general service costs.

The Intermediary determined that the Provider's methodology resulted in an improper allocation of costs to the Medicare program. Specifically, it inappropriately shifted overhead costs attributable to the hospital's operations to the HHA, which is reimbursed on a cost basis.

Consequently, for FYE April 30, 1996, the Intermediary removed the square footage relating to the leased satellite offices from the statistics reported on Worksheet B-l, which allocate Old Capital Related Costs - Buildings & Fixtures, New Capital Related Costs - Buildings & Fixtures, and Operation of Plant costs, to the HHA cost center. However, for FYE April 30, 1997 the Intermediary removed only the square footage relating to the leased satellite offices (5,173) from New Capital Related Costs - Buildings & Fixtures, and New Capital Related Costs – Moveable Equipment Costs

to the HHA cost center on Worksheet B-1. In addition, for the cost reporting periods at issue, the Intermediary reversed the Provider's reclassification of the lease expense from the HHA cost center to the capital cost centers, which effectively, directly assigned the lease costs back to the HHA cost center.[1]

The Intermediary incorporated its audit adjustments into a Notice of Amount of Program Reimbursement (NPR) for FYE April 30, 1996 on May 15, 1998 and issued the NPR for FYE April 30, 1997 on February 25, 1999. The Provider timely appealed the NPRs to the Board on November 9, 1998 and July16, 1999, respectively. The Provider's filing meets the jurisdictional requirements in accordance with 42 C.F.R. §§ 405.1835-.1841. The Medicare reimbursement effect for both of the appeals is approximately $117,805. The Provider is represented by Carel T. Hedlund, Esquire, of Ober, Kaler, Grimes & Shriver, P.C. The Intermediary is represented by Thomas Bruce, Esquire, of Mutual of Omaha Insurance Company.

PROVIDER'S CONTENTIONS:

The Provider contends that HHA branch offices rental expenses are capital-related costs. The regulation at 42 C.F.R. § 413.130(a) defines capital cost to include lease and rental costs.[2] The regulation provides, in pertinent part:

> Leases and rentals. (1) . . . . leases and rentals, including licenses and royalty fees, are includable in capital-related costs if they relate to the use of assets that would be depreciable if the provider owned them outright or they relate to land, which is neither depreciable nor amortizable if owned outright. The terms "leases" and "rentals of assets" signify that a provider has possession, use, and enjoyment of the assets.

42 C.F.R. § 413.130(a).

The HHA branch offices would qualify as a depreciable asset if the Provider owned the buildings outright and had possession, use and enjoyment of the offices. Thus, the rental costs of the Provider's HHA branch offices qualify as capital costs under the regulations and were properly classified as such.

Furthermore, the Provider claims that its classification of the rental expenses to the Capital-Related Building Cost Center is consistent with its treatment of such costs for all its departments in the Provider's capital base year. In the capital base year, the Provider classified the HHA rental expenses and all other hospital department rental expenses as capital-related costs. The Provider has consistently classified these expenses as capital-related costs throughout the capital PPS transition period.

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[1] See Intermediary position paper Exhibit I-1
[2] See Provider position paper at Exhibit P-8

While the Provider's cost finding method may not be the only permissible manner in which to classify and allocate these capital-related costs, it is an acceptable way, as demonstrated by the Intermediary's review of this method in the Provider's capital base year.[3] The Intermediary reviewed and accepted the Provider's method for classifying and allocating these costs, with minor adjustments not relevant here.[4] The Provider's method of classifying and allocating the HHA rental expenses thus is a permissible method.

The Provider insists that the Intermediary has violated the rule of consistency by reclassifying the Provider's capital-related costs in a manner inconsistent with the method used in the Provider's capital base year. As a result of the reclassification, the Provider's capital-related costs are allocated in a different manner than in the capital base year. This affects not only allocations to the Provider's HHA, but also causes a different proportion of costs to be allocated to the inpatient portion of the hospital than was allocated in the capital base year. This is precisely one of the results the requirement for consistency aimed to eliminate. In the preamble to the final rule of PPS inpatient hospital capital-related costs, HCFA addressed the need for consistency in cost allocation of old capital costs throughout the capital PPS transition period in order to be consistent with the determination of the hospital-specific rate.

> Since the hospital-specific rate affects not only the payment to fully
> prospective hospitals but also the determination of the applicable payment methodology, we believe that consistent cost allocation is important for high capital cost hospitals as well as low capital cost hospitals. Therefore, we are providing that a hospital that has not directly assigned capital to the various patient care cost centers in the past, cannot begin to directly assign these costs in the future.

56 Fed. Reg. 43,396 (Aug. 30, 1991).[5] As further clarification, HCFA provided the following examples: "if the hospital has allocated moveable equipment on square footage, it would be required to allocate moveable equipment that qualifies as old capital on square footage during the transition. Similarly, if the hospital has not assigned fixed capital by building component, the hospital cannot allocate old capital on this basis in the future." Id.

The Provider asserts that the Intermediary's adjustments to the Provider's reclassification of the HHA rental expenses result in these expenses being directly allocated to the HHA, which is inconsistent with the treatment of these costs during the Provider's capital base year. The preamble to the final rule, discussed above, provides that capital costs that were not previously directly assigned to patient care cost centers cannot begin to be directly assigned during the transition period. The

[3] See Provider position paper Exhibit P-7
[4] See Provider position paper Exhibit P-7.
[5] See Provider position paper Exhibit P-9.

Provider did not directly assign these costs to the HHA in the capital base year. Moreover, the Provider has not requested that its cost finding methods be changed.

By directly assigning these costs, the Intermediary has in effect altered the cost-finding method, which causes a different proportion of capital costs to be allocated to the inpatient portion of the hospital. The Provider's Exhibit P- 10 shows that after the Intermediary's adjustment, the inpatient routine service cost centers receive an additional $32,661 in cost allocations, which includes increased capital cost allocations. The Intermediary' s position, therefore, is in violation of the rule of consistency and is also contrary to the directive provided by HCFA in the preamble to the final rule.

The Provider contends that the regulations, preamble and manual provisions are clear that the cost finding methods used during the capital-related cost PPS transition period must be consistent with the methods used in the capital-related cost base year. The regulation at 42 C.F.R. § 405.1867 states: "the Board must comply with all the provisions of title XVIII of the Act and regulations issued thereunder."[6] See also White Memorial Med. Ctr. v. Blue Cross and Blue Shield Association/Blue Cross and Blue Shield of Cal., PRRB Dec. January 15, 1998, No. 98-D20, Medicare and Medicaid Guide (CCH) ¶ 46,009.[7]

While there does not appear to be case law directly on point regarding the rule of consistency as it applies to treatment of capital-related costs during the capital-related PPS transition period, there is analogous case law upholding a similar "rule of consistency" that existed during the four-year PPS transition period for inpatient operating costs. See 42 C.F.R. § 412.113 (1986).[8]

The Provider notes that in Parkway Hosp., Inc. v. Empire Blue Cross and Blue Shield, PRRB Dec. Hearing No. 99-D35, April 7, 1999, Medicare and Medicaid Guide (CCH) ¶ 80,180 remand HCFA Adm'r, Medicare and Medicaid Guide (CCH) ¶ 46,359 ("Parkway") (Apr. 27, 1998),[9] the provider claimed capital pass-through reimbursement for certain equipment lease payments. The FYs at issue were 1986 and 1987, which were PPS transition periods. The provider's base year for the inpatient hospital PPS transition period was 1982. In the base year, the lease-rental costs at issue were not classified as capital-related costs; rather, the costs were included in the provider's hospital specific rate (HSR). The Intermediary reclassified the lease-rental costs from capital-related costs to operating expenses in order to avoid duplicate payment by the Medicare program: payment once through the HSR and again as capital pass-through costs. The Intermediary based its reclassification on the Medicare consistency rule at 42 C.F.R. § 412.113 and HCFA Pub. 15-1 § 2802, which require that capital-related costs be determined consistently with the

[6] See Provider position paper Exhibit P-11.
[7] See Provider position paper Exhibit P-12.
[8] See Provider position paper Exhibit P-13.
[9] See Provider position paper Exhibit P-14.

treatment during the PPS base period. The Board upheld the Intermediary's reclassification based on the regulation requiring consistent treatment.

Similarly, in Foothill Presbyterian Hosp. v. Blue Cross and Blue Shield Association/Blue Cross of Cal., PRRB Dec. No. 94-D27, (Apr. 14, 1994) Medicare and Medicaid Guide (CCH) ¶ 42,251 ("Foothill"),[10] the Board held that the Provider, an acute care hospital, must treat its laundry and linen costs as operating costs consistent with such cost treatment during the Provider's PPS base year. The Provider attempted to reclassify its laundry and linen cost for cost reporting period ending September 30, 1996 as capital-related pass-through costs. The Intermediary reclassified the cost as operating costs, citing the rule of consistency at 42 C. F.R. § 412.113(a) which states, "[f]or cost reporting periods beginning before October 1, 1986, the capital-related costs for each hospital must be determined consistently with the treatment of such costs for purposes of determining the hospital-specific portion of the hospital's prospective payment rate."

The Provider had treated the laundry and linen service costs as operating costs in the base year; therefore, to permit the Provider to reclassify the costs as capital-related would violate the rule of consistency.

The Board in both Parkway and Foothill stressed the importance of consistency in cost finding methods during the PPS transition period, given that capital-related costs were excluded from the definition of inpatient operating costs for the period at issue, resulting in capital-related costs not being included in the HSR calculation. Consistency is equally vital to the case at hand involving the capital-related PPS transition period.

The Provider asserts that the HHA satellite locations receive benefit from the Capital-related Building Cost Centers (Old and New). These cost centers contain the Hospital's depreciation related to capital assets, including leasehold improvements. From time to time, the Provider incurs costs for various leasehold improvements for the spaces that it leases. These leasehold improvements are then depreciated as fixtures, and the depreciation is included in the Capital-related building cost center. See HCFA Pub. 15-2 § 1313.[11] The only way this depreciation gets allocated is on the basis of square footage.[12]

The Provider emphasizes that it has adopted a uniform method for treating these leasehold improvements for all space that it leases for its departments by classifying them as fixed assets which are included in the Capital-related building cost center. In any given year a particular leased space may or may not have depreciation attributable to an improvement, but this method allows for a uniform method of allocating depreciation based on square footage for all leased space. The Intermediary cannot change this cost-finding method from year to year simply

[10] See Provider position paper Exhibit P-15.
[11] See Provider position paper Exhibit P-16.
[12] See Worksheet B-1, Provider position paper Exhibit P-17.

because in one year a particular leasehold may not have had any depreciation attributable to an improvement. The same leasehold may have depreciation attributable to an improvement in the prior year or in the next year.

Cost-finding is, by definition, not an exact measurement, but rather an informal procedure that relies on surrogate statistics such as square feet to allocate costs.[13] Medicare has long recognized that the step-down method of cost-finding may result in any given instance in an over or under-allocation of costs, but that this averaging method provides the advantage of a uniform approach, and that the inconsistencies even out. See Kingsbrook Jewish Med. Ctr. v. Blue Cross Ass'n/Blue Cross and Blue Shield of Greater N.Y. PRRB Dec. No. 76-D74, Medicare and Medicaid Guide (CCH) ¶ 28,300.[14]

Because the Provider incurred leasehold improvement expense for its home health satellite locations, those locations should receive a portion of the depreciation included in the Capital-related building cost centers, because that cost center "serves" the satellite locations. Because square footage is the approved statistic for allocating depreciation costs, the Intermediary erred in removing the square footage for the satellite locations as a statistic to allocate Capital-related building costs.

The Provider contends that the Intermediary has ignored the most significant aspect of the issue before the Board, i.e., the requirement in the Medicare regulations that a Provider must maintain consistent cost finding methods during the capital-PPS transition period. The Intermediary has based its position solely on the general principle of cost shifting. It is the Intermediary's position that the Provider's cost finding methods resulted in cost shifting. The Provider contends that its use of an established cost finding method, which the Intermediary accepted as a permissible method during the capital base-year audit, does not equate with cost shifting. Moreover, even though the general cost shifting principle is important to the Medicare reimbursement system, it cannot be used to override a specific regulation requiring that hospitals use throughout the transition period the same cost finding methods used in their capital base year.

It is the Provider's position that the Medicare regulations mandate that the Provider use the same method of classification and allocation that it used in the capital base year. The Intermediary is bound by that regulation and has no authority to ignore it.

INTERMEDIARY'S CONTENTIONS:

The Intermediary claims that the Provider has not documented that its methodology of reclassifying HHA building rent to the building capital cost centers and

[13] See HCFA Pub. 15-1 § 2302.7 at Provider position paper Exhibit P-20.
[14] See Provider position paper Exhibit P-21.

subsequently allocating these costs back to the HHA cost center on the basis of leased square footage results in a more accurate and proper allocation of costs to the Medicare program. In fact, the Provider's methodology inappropriately shifts costs to the Medicare program.

The Intermediary refers to Community Health and Counseling Services v. Blue Cross and Blue Shield Association/Associated Hospital Services of Maine PRRB Dec. No. 99-D48, May 6, 1999, Medicare and Medicaid Guide (CCH) ¶ 80,188 ("Community") because it feels that the text of this decision captures the essence of the situation presently before the Board.[15] The applicable excerpts are as follows:

> [t]he cost-shifting prohibition is the most fundamental principle of the Medicare program. Therefore, other regulations and manual instructions must yield where there is perceived conflict.

Community at 200,852.

The Intermediary points to Medicare law at 42 U.S.C. § 1395x(v)(1)(A), which states that:

> the Secretary in promulgating regulations to define and determine reasonable cost, must ensure that, under the methods of determining costs, the necessary costs of efficiently delivering covered services to individuals covered by the insurance programs established by this title will not be borne by individuals not so covered, and the costs with respect to individuals not so covered will not be borne by such insurance programs.[16]

The Intermediary contends this is the cost-shifting prohibition, and may be found in various forms in the Medicare regulations at 42 C.F.R. §§ 413.5(a), 413.9(b)(1), 413.50(a) and (b), and 413.53(a); manual instructions at HCFA Pub. 15-1 §§2200.1 and 2207.1; and numerous administrative and court decisions.[17] The Intermediary avers that this principle is so fundamental that regulations and manual instructions have often been struck down in its wake, or interpreted or re-written to be consistent with its goal, accuracy of reimbursement. See Humana of South Carolina, Inc. v. Mathews 419 F. Supp. 253 (D.D.C. 1976), (striking 42 C.F.R. § 405.429(a)); No. 85-3342 (D.D.C. April 4, 1988) Howard University v. Bowen, Medicare and Medicaid Guide (CCH) ¶ 37,057 (interpreting 42 C.F.R. § 405.425(c)); Providence Hospital of Toppenish, et al. v. Shalala, 52 F. 3d 213 (9th Cir. 1995); Fairview Hospital and Healthcare Services v. Bowen, Civil Action No. 4-87-316, (D. Minn. March 21, 1988), Medicare and Medicaid Guide (CCH) ¶ 37,063 ; Drum Hills Nursing Home, lnc. v. Aetna Life and Casualty Company, PRRB Dec. No. 83-D34, February 18,

[15] See Intermediary position paper Exhibit I-2.
[16] See Intermediary position paper Exhibit I-3
[17] See Intermediary position paper Exhibits I-4 and 1-5

1983, Medicare and Medicaid Guide (CCH) ¶ 32,440, aff'd, HCFA Admin. Dec., April 7, 1983, Medicare and Medicaid Guide (CCH) ¶ 32,839 (interpreting HCFA Pub. 15-1 § 2126.2, which was later re-written, as a result of the decision, to eliminate the cost-shifting).

The Intermediary contends that the cost-shifting prohibition principle does not allow for exceptions or extensions, whether for longstanding past practice or even prior explicit permission. Consistency is no bar to correction of cost-shifting. Moreover, none of the decisions noted above that show how strongly the cost-shifting prohibition principle has been enforced give any hint of any exceptions or extensions to the application of the principle for any reason.

The Intermediary also notes that in Community the Board cited two cases wherein accuracy was the desired outcome, Glenwood Regional Medical Center v. Blue Cross and Blue Shield Association et al., PRRB Dec. No. 96-D18, March 7, 1996, Medicare and Medicaid Guide (CCH) ¶ 44,066, HCFA Admin. Declined review, April 29 1996 and Oklahoma Medical Center v. Blue Cross and Blue Shield of Oklahoma, HCFA Admin. Dec., October 28, 1992, Medicare and Medicaid Guide (CCH) ¶ 41,014. Lastly, it was stated that, "the Board does not find merit in the Provider's argument that since the Intermediary did not propose similar audit adjustments in prior years that it was thereby endorsing the Provider's cost finding methodology. . . . The Board notes that intermediaries audit on an exception basis. . . .This concept is supported by the Alacare Home Health Services, Inc. v. Sullivan,891 F. 2d 850 (11th Cir. 1990) case wherein the court stated that a number of factors are involved in an intermediary's evaluation of a Provider's cost, therefore each fiscal year must stand on its own." Id.

The Intermediary objects to reversing the audit adjustments because the Provider's methodology inappropriately shifts costs to the Medicare program. As the Intermediary's Exhibits I-6 and I-7 indicate, the Provider's treatment results in an additional $125,131 in Old Capital Related Building, New Capital Related Building, and Operation of Plant costs being allocated to the Administration & General - HHA cost center ($32,585 + $55,350 + $37,196).[18] These were the three General Service cost centers for which square feet statistics relating to the HHA leased space were removed. Furthermore, after considering the impact that the Intermediary's adjustments have on the allocation process, as illustrated in Intermediary Exhibit I-7, the net effect after step-down is $82,736 in additional hospital-related overhead costs being allocated to the HHA A&G cost center through the Provider's methodology. This $82,736 translates into an additional $79,201 in reimbursable cost to the HHA, as the Worksheet H series indicates in Intermediary Exhibit I-6. Intermediary Exhibit I-8 shows, the net reimbursement effect of the Intermediary's adjustments 28 and 31 is $68,383, because of the positive impact to the Provider Part B and Skilled Nursing Facility Part A reimbursement.

[18] In this paragraph the Intermediary is referring to FYE 04/30/96 only.

The Intermediary insists that its audit workpapers clearly demonstrate how the conclusions for the adjustments in question were reached.[19] Much of the information regarding the allocation of General Service cost centers came from conversations with the Provider's internal auditor. It should be noted that the Intermediary did allow the square footage (3,500) relating to that portion of the HHA's operation housed in one of the two hospital-owned buildings. In addition, for FYE April 30, 1996, all square footage (11,000), was allowed for the allocation of Old Capital Related Costs - Moveable Equipment, New Capital Related Costs - Moveable Equipment, Maintenance & Repairs, and Housekeeping based on these conversations. The Provider simply could not demonstrate how the Old and New Capital Related Building and Operation of Plant cost centers "service" the leased satellite offices in order to justify cost allocations from them.

The Intermediary asserts that HCFA Pub. 15-1 § 2302.4 provides a definition for directly allocable costs by stating that, "[d]irectly allocable costs are chargeable, based on actual usage rather than a statistical surrogate."[20] Furthermore, the Provider's trial balance[21] demonstrates how the HHA rent expenses are recorded in the ongoing normal accounting process; that they are grouped with "Home Health Care –Other" expenses. This treatment agrees with the conditions for directly assigning General Service costs described in HCFA Pub. 15-1 § 2307.[22]

In conclusion, the Intermediary contends that the Provider has not documented that its methodology of reclassifying HHA building rent to the building capital cost centers and subsequently allocating these costs back to the HHA cost center on the basis of leased square footage results in a more accurate and proper allocation of costs to the Medicare program. In fact, the Intermediary has clearly demonstrated that the Provider's methodology inappropriately shifts costs to the Medicare program. Adjustments 28 and 31 provide for more accurate cost finding and therefore should not be reversed.

CITATION OF LAW, REGULATIONS AND PROGRAM INSTRUCTIONS:

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

   § 1395x(v)(1)(A) - Reasonable Cost

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

   §§ 405.1835-.1841 - Board Jurisdiction

[19] See Intermediary position paper Exhibit I-9.
[20] See Intermediary position paper Exhibit I-10
[21] See Intermediary position paper Exhibit I-11
[22] See Intermediary position paper Exhibit 1-12

§413.5(a) - Cost Reimbursement: General

§413.9(b)(1) - Cost Related to Patient Care: Definition of Reasonable Costs

§413.50 et seq. - Apportionment of Allowable Cost

§413.53(a) - Determination of Cost of Services to Beneficiaries. Principle

§413.130 et seq. - Introduction to Capital-Related Costs

§ 405.1867 - Sources of Board's Authority.

§ 412.113 (1986) et seq. - Other Payments

§ 412.302(d) - Introduction to Capital Costs

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

§2200.1 - Principle of Cost Apportionment

§2207.1 - Methods of Cost Apportionment for Part A Inpatient Services: Objectives

§2307 - Direct Assignment of General Service Costs.

§ 2802 - Payment Rates during Transition under Hospital Prospective Payment System

§ 2302 et seq.	-	Cost Finding
§ 2807.2	-	Consistent Cost Finding During Transition Period

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

§ 1313	-	Worksheet B, Part I –Cost Allocation – General Service Cost and Worksheet B-1- Cost Allocation – Statistical Basis

5. Case Law:

Humana of South Carolina, lnc. v. Mathews, 419 F. Supp. 253 (D.D.C. 1976)

Howard University v. Bowen, No. 85-3342, (D.D.C. April 4, 1988), Medicare & Medicaid Guide (CCH) ¶ 37,057

Providence Hospital of Toppenish, et al. v. Shalala, 52 F.3d 213 (9th Cir. 1995)

Fairview Hospital and Healthcare Services v. Bowen, Civil Action No. 4-87-316, (D. Minn. March 21, 1988), Medicare and Medicaid Guide (CCH) ¶37,063

Drum Hills Nursing Home, lnc. v. Aetna Life and Casualty Company, PRRB Dec. No. 83-D34, February 18, 1983, Medicare and Medicaid Guide (CCH) ¶ 32,440, affd, HCFA Admin. Dec., April 7, 1983, Medicare and Medicaid Guide (CCH) ¶ 32,839

Glenwood Regional Medical Center v. Blue Cross and Blue Shield Association et al., PRRB Dec. No. 96-D18, March 7, 1996, Medicare and Medicaid Guide (CCH) ¶ 44,066, HCFA Admin. declined review, April 29, 1996.

Oklahoma Medical Center v. Blue Cross and Blue Shield of Oklahoma, HCFA Admin. Dec., October 28, 1992, Medicare and Medicaid Guide (CCH) ¶ 41,014

Alacare Home Health Services, Inc. v. Sullivan, 891 F. 2d 850 (11th Cir. 1990)

White Memorial Med. Ctr. v. Blue Cross and Blue Shield Association/Blue Cross and Blue Shield of Cal., PRRB Dec. No. 98-D20, (Jan. 15, 1998) Medicare and Medicaid Guide (CCH) ¶ 46,009

Parkway Hosp., Inc. v. Empire Blue Cross and Blue Shield, PRRB Dec. No. 99-D35, Apr. 7, 1999 Medicare and Medicaid Guide (CCH) ¶ 80,180 rem'd HCFA Admin Dec., (April, 27, 1998) Medicare and Medicaid Guide (CCH) ¶ 46,359

Foothill Presbyterian Hosp. v. Blue Cross and Blue Shield Association/Blue Cross of Cal.,PRRB Dec. No. 94-D27, Apr. 14, 1994, Medicare and Medicaid Guide (CCH) ¶ 42,251

Kingsbrook Jewish Med. Ctr. v. Blue Cross Association/Blue Cross and Blue Shield of Greater N.Y., PRRB Dec. No. 76-D74, [1976 Transfer Binder] Medicare and Medicaid Guide (CCH) ¶ 28,300

Community Health and Counseling Services v. Blue Cross and Blue Shield Association/Associated Hospital Services of Maine, PRRB Dec. No. 99-D48, May 6, 1999, Medicare and Medicaid Guide (CCH) ¶ 80,188

6. Other:

56 Fed. Reg. 43,396 (August 30, 1991)

FINDINGS OF FACT, CONCLUSION OF LAW AND DISCUSSION:

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

The Board finds that the HHA branch offices rental expenses are capital-related costs. The regulation at 42 C.F.R. § 413.130(a) defines capital cost to include lease and rental costs. The regulation provides, in pertinent part:

> Leases and rentals. (1) . . . . leases and rentals, including licenses and royalty fees, are includable in capital-related costs if they relate to the use of assets that would be depreciable if the provider owned them outright or they relate to land, which is neither depreciable nor amortizable if owned outright. The terms 'leases' and 'rentals of assets' signify that a provider has possession, use, and enjoyment of the assets.

The Board notes that in accordance with this regulation the HHA branch offices would qualify as a depreciable asset if the Provider owned the buildings outright, and the Provider had possession, use and enjoyment of the offices. Thus, the Board finds that the rental costs associated with the HHA branch offices qualify as capital costs under the regulations and should be classified as such.

Furthermore, the Board finds that the HHA satellite locations receive benefit from the Capital-Related Building cost centers (Old and New). The capital-related cost centers contain the Provider's depreciation expense related to capital assets, including leasehold improvements. There is evidence in the record that the hospital incurred costs for various leasehold improvements for the spaces that it leases.[23] These leasehold improvements are then depreciated as fixtures, and the depreciation is included in the Capital-Related Building cost center.[24] The Board finds that the most accurate method of allocation of depreciation expense is on the basis of square footage.[25]

In addition, the Board notes that there is no dispute that the Provider's classification of the rental expenses to the Capital-Related Building cost center was consistent with its treatment of such costs in its capital base year. Also, the Board notes that there is no argument that the Provider classified the HHA rental expenses and all other hospital department rental expenses as capital-related costs. The Board further notes that there is no dispute that the Provider has consistently classified these expenses as capital-related costs throughout the capital PPS transition period. Therefore, for consistency purposes, and in accordance with HCFA Pub. 15-1 § 2807.2 and 42 C.F.R. § 412.302(d)[26] "a hospital must follow consistent cost finding methods for classifying and allocating capital-related costs." The Board finds this to be especially true in this case, as the Intermediary has allowed these same costs as capital-related, consistent with the capital base year.

In addition, if the Board were to allow the Intermediary's reclassification of capital-related costs in this case, the Provider's capital-related costs would be allocated in a different manner than in the capital base year. This affects not only allocations to the Provider's HHA, but also causes a different proportion of costs to be allocated to the inpatient portion of the hospital than was allocated in the capital base year. The Board finds the Intermediary's treatment of capital costs to be in direct conflict with HCFA Pub. 15-1 § 2807.2 and 42 C.F.R. § 412.302(d), as stated above.

Regarding the Intermediary's argument on the general principle of cost-shifting, the Board finds that the Provider's use of an established cost finding method, which the Intermediary accepted as a permissible method during the capital base-year audit, does not equate with cost shifting. The Board further finds that the cost-shifting methodology should not be used to override a specific regulation requiring that hospitals use throughout the transition period the same cost finding methods used in their capital base year.

Finally, the Board concludes that the lease and depreciation expense related to the satellite offices should be allowed as capital-related costs along with operation of plant costs to be allocated to the A & G - HHA cost center.

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[23] See Provider position paper Exhibits P-18 and P-19.
[24] See Provider position paper Exhibit P-16.
[25] See Worksheet B-1, Provider's position paper Exhibit P-17.
[26] See Provider position paper Exhibits P-3 and P-4.

DECISION AND ORDER:

The Intermediary's adjustments to disallow the HHA satellite offices as capital-related costs are improper. In addition, the Intermediary's adjustments to eliminate the allocation of capital-related and operation of plant costs to the A & G - HHA are improper. Therefore, the Intermediary's adjustments are reversed.

BOARD MEMBERS PARTICIPATING:

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

DATE OF DECISION: October 16, 2002

FOR THE BOARD

Suzanne Cochran, Esquire
Chairman