PROVIDER REIMBURSEMENT REVIEW BOARD
DECISION

2026-D21

PROVIDER –
St. Francis Hospital

PROVIDER NUMBER: 23-1337

vs.

MEDICARE CONTRACTOR –
WPS Government Health Administrators (J-5)

HEARING DATE –
June 20, 2024

Cost Reporting Periods Ended –
September 30, 2017,
September 30, 2018,
September 30, 2019

CASE NUMBERS – 20-0514
21-0656
22-0852

INDEX

ISSUE STATEMENT:..... 2
DECISION: 2
INTRODUCTION: 2
STATEMENT OF RELEVANT FACTS: 3
STATEMENT OF RELEVANT LAW:..... 5
DISCUSSION, FINDING OF FACTS, AND CONCLUSIONS OF LAW:……..... ……...16
DECISION: 23

ISSUE STATEMENT:

Whether the Provider is entitled to Medicare reimbursement related to state taxes that were removed by WPS Government Health Administrators (the "Medicare Contractor").[1]

DECISION:

After considering the Medicare law and regulations, the arguments presented, and the evidence admitted, the Provider Reimbursement Review Board ("Board") finds that the Medicare Contractor properly removed the entire Quality Assurance Assessment Program ("QAAP") tax paid by the Provider in Fiscal Years ("FY") 2017 through 2019, as there was no evidence of the QAAP tax paid or the QAAP payments received to calculate the "net tax expense" as defined by the regulations.

INTRODUCTION:

St. Francis Hospital ("St. Francis" or "Provider") is a Critical Access Hospital ("CAH") located in Escanaba, Michigan.[2] As a CAH, St. Francis is reimbursed at 101 percent of its reasonable costs incurred in providing inpatient hospital services to Medicare beneficiaries.[3] St. Francis' assigned Medicare contractor[4] is WPS Government Health Administrators.

St. Francis was subject to – and paid – a hospital assessment tax known as the Quality Assurance Assessment Program ("QAAP") levied by the State of Michigan for FYs 2017 through 2019.[5] The Provider disputes the Medicare Contractor's adjustments, which reduced the costs by the amount of the Provider's QAAP tax claimed for reimbursement by payments it received from the State of Michigan for FYs 2017 through 2019.[6]

St. Francis timely appealed the issue to the Board and met the jurisdictional requirements for a hearing. The Board conducted a live consolidated hearing on June 20, 2024. The Provider was represented by Mark D. Polston, Esq. and Alec Pivec, Esq. of King & Spalding, LLP. The Medicare Contractor was represented by Scott Berends, Esq. of Federal Specialized Services.

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[1] Hearing Transcript [hereinafter "Tr."] at 5 (Jun. 20, 2024).
[2] *See* Provider Revised Consolidated Final Position Paper at 1 (June 4, 2024).
[3] *Id.*, citing 42 U.S.C. § 1395f(l)(1) and 42 U.S.C. § 1395x(v)(1)(A).
[4] CMS' payment and audit functions under the Medicare program were historically contracted to organizations known as fiscal intermediaries ("FIs") and these functions are now contracted with organizations known as Medicare Administrative Contractors ("MACs"). The term "Medicare contractor," as used herein, refers to both FIs and MACs as appropriate and relevant.
[5] *See* Provider's Revised Consolidated Final Position Paper at 3.
[6] *See id.* at 1.

STATEMENT OF RELEVANT FACTS:

Michigan uses QAAPs "to help generate Restricted revenue to reduce [General Fund/General Purpose ("GF/GP")] costs and enhance Medicaid reimbursements to certain Medicaid provider groups."[7] The QAAPs – also called provider taxes – are "broad-based taxes on medical providers."[8] It is possible for a low-Medicaid volume hospital to pay provider taxes that exceed the Medicaid rate increase they receive (a net loss); however, according to a fiscal analysis of Michigan Senate Bill 957 (2016), most hospitals pay less in provider tax than they receive from the Medicaid rate increase (a net gain).[9] Each year the Michigan Department of Health and Human Services ("MDHHS") calculates the percentage of the QAAP tax proceeds that will make up the retention amount. In FYs 2017, 2018, and 2019, MDHHS announced by letter that the retention amount represented 35.2%,[10] 34.0%,[11] and 34.7%,[12] respectively, of QAAP revenues in those years. Specifically, the letters stated:

> Dear Hospital Administrator,
>
> RE: Quality Assurance Assessment
>
> The Michigan Public Health Code establishes a quality assurance assessment program for hospitals to fund the local share of certain Medicaid payments to Michigan hospitals. A portion of this assessment is collected to fund enhanced Medicaid levels of reimbursement to Michigan hospitals. The remainder, otherwise known as the State retention amount, is assessed, pursuant to 33.20161(14)(i) of the Public Health Code, to offset general fund/general purpose revenue originally appropriated for hospital services and therapy.
>
> In its Fiscal Year 2011 Medicare inpatient prospective payment system (IPPS) final rule, CMS-1498-F, published August 16, 2010, the Centers for Medicare & Medicaid Services (CMS) clarified its policy on how hospitals are to report tax costs. Specifically, this clarification applies to the treatment of Medicaid provider related taxes for purposes of Medicare cost reporting and reimbursement. Subsequent to this rule, CMS updated section 2122, TAXES, of the Medicare Provider Reimbursement Manual (PRM) to include the following clarifying language:
>
> > "While a tax may fall under a category that is generally accepted as an allowable Medicare cost, the provider may only treat the net tax

[7] Exhibit [hereinafter "Ex."] P-2 (Fiscal Analysis of Senate Bill 957 dated 6-14-16) at 1. (The Board notes that these appeals have individual Provider Preliminary Position Papers, a Consolidated Provider Revised Final Position Paper, and a Consolidated Provider Responsive Final Position Paper. Exhibits cited will refer to the Consolidated Revised Final Position Paper unless otherwise noted.)
[8] *Id*.
[9] *See id*.
[10] Ex. P-4 at 2.
[11] *Id.* at 5.
[12] *Id.* at 7.

> expense as the reasonable cost actually incurred for Medicare payment purposes. The net tax expense is the tax paid by the provider, reduced by payments the provider received that are associated with the assessed tax."
>
> In response to hospitals' request for detail of the components of the hospital quality assurance assessment program, […]% of the FY […] hospital quality assurance assessment is allocable to the State retention amount.
>
> If you have questions regarding this issue, please contact Andrew Schalk of the Actuarial Division at 517- 284-1195 or schalka@michigan.gov. [13]

The Senate Bill 957 for the State of Michigan gives a simplified example of how a QAAP functions, stating: Using round numbers, the State could potentially tax hospitals $800.0 million, use $200.0 million of that to offset GF/GP funding, and then use the remaining $600.0 million, along with $1,100.0 million in Federal Medicaid match, to increase provider rates by $1,700.0 million. The net result is that the State is better off by $200.0 million and the providers, as a whole, are better off by $900.0 million ($1,700.0 million in increased Medicaid payments less $800.0 million in tax paid.[14]

The table below[15] represents QAAP taxes St. Francis paid for the cost reporting periods in dispute. St. Francis reported these taxes in the administrative and general ("A&G") cost center of its applicable cost reports.[16]

In the same table, St. Francis also calculated the "Payment Pool Amount" component of its QAAP tax liability.[17] This was calculated as the product of the Total QAAP Tax Paid and the inverse of the state-determined retention percentage (reflecting the portion of the QAAP Tax not retained by the state).[18]

St. Francis made adjustments, via Worksheet A-8, to remove the Payment Pool Amount, leaving only the portion of the tax that the state kept for itself (the "state retention amount") in each applicable cost report. [19]

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[13] Ex. P-4 at 1-2, 5, and 7. *See discussion at* Tr. 105 – 114, 132, 169 – 171, 186 – 187, 190 – 192. The Board notes that in these letters the State of Michigan Department of Health and Human Services cites to "33.20161(14)(i) of the Public Health Code." The Board notes that this citation appears to be a typographical error, a holdover from the previous version of the law effective until Sept. 30, 2015. The Board relies on MICH. COMP. LAWS § 333.20161(12)(i) (eff. June 21, 2016 to June 27, 2018 and eff. June 28, 2018 to Sept. 29, 2019), as shown *infra*, Statement of Relevant Law.

[14] Ex. P-2 at 1.

[15] *See* Provider Revised Consolidated Final Position Paper at 7.

[16] *See id.* at 6-7.

[17] *Id.* at 6.

[18] *Id.*

[19] Ex. P-5 (Worksheet A-8, As-Filed Cost Reports for 2017 and 2018) (The Board notes that although the 3rd example in this Exhibit is identified as FY 2019, it is a duplicate of the 2018 worksheet. However, Ex. P-5 included with the Provider's Preliminary Position Paper in Case No. 22-0852 includes the correct 2019 worksheet).

Fiscal Year	Total QAAP Tax Paid and Reported in A&G	Retention % / Payment Pool %	Payment Pool Amount	State Retention Amount
2017	$2,231,544	35.2 % / 64.8 %	$1,446,041	$785,503
2018	$1,871,798	34 % / 66 %	$1,235,387	$636,411
2019	$2,259,907	34.7 % / 65.3 %	$1,475,719	$784,188

At audit, the Medicare Contractor adjusted to remove the state retention amounts.[20] Consequently, the eliminations of the state retention amounts are the Medicare cost report adjustments in dispute in the instant appeals.

STATEMENT OF RELEVANT LAW:

A. MICHIGAN QUALITY ASSURANCE ASSESSMENT PROGRAM

The state of Michigan sets forth its fee and assessment schedule in MICH. COMP. LAWS § 333.20161 (June 21, 2016 to June 27, 2018):

> (1) The department shall assess fees and other assessments for health facility and agency licenses and certificates of need on an annual basis as provided in this article. Until October 1, 2019, except as otherwise provided in this article, fees and assessments shall be paid as provided in the following schedule:
>
> * * *
>
> | | |
> |---|---|
> | (h) Subject to subsection (12), quality assurance assessment for hospitals….. | at a fixed or variable rate that generates funds not more than the maximum allowable under the federal matching requirements, after consideration for the amounts in subsection (12)(a) and (i). |
>
> * * *
>
> (10) Except as otherwise provided in this section, the fees and assessments collected under this section shall be deposited in the state treasury, to the credit of the general fund. The department may use the unreserved fund balance in fees and assessments for the criminal history check program required under this article.
>
> * * *

[20] *See* Exs. P-6 (Worksheet A-8, Final Cost Reports) and P-7 (Audit Adjustment Reports).

(12) The quality assurance dedication is an earmarked assessment collected under subsection (1)(h). That assessment and all federal matching funds attributed to that assessment shall be used only for the following purpose and under the following specific circumstances:

(a) To maintain the increased Medicaid reimbursement rate increases as provided for in subdivision (c).

(b) The quality assurance assessment shall be assessed on all net patient revenue, before deduction of expenses, less Medicare net revenue, as reported in the most recently available Medicare cost report and is payable on a quarterly basis, with the first payment due 90 days after the date the assessment is assessed. As used in this subdivision, "Medicare net revenue" includes Medicare payments and amounts collected for coinsurance and deductibles.

(c) Beginning October 1, 2002, the department shall increase the hospital Medicaid reimbursement rates for the balance of that year. For each subsequent year in which the quality assurance assessment is assessed and collected, the department shall maintain the hospital Medicaid reimbursement rate increase financed by the quality assurance assessments.

(d) The department shall implement this section in a manner that complies with federal requirements necessary to ensure that the quality assurance assessment qualifies for federal matching funds.

(e) If a hospital fails to pay the assessment required by subsection (1)(h), the department may assess the hospital a penalty of 5% of the assessment for each month that the assessment and penalty are not paid up to a maximum of 50% of the assessment. The department may also refer for collection to the department of treasury past due amounts consistent with section 13 of 1941 PA 122, MCL 205.13.

(f) The hospital quality assurance assessment fund is established in the state treasury. The department shall deposit the revenue raised through the quality assurance assessment with the state treasurer for deposit in the hospital quality assurance assessment fund.

(g) In each fiscal year governed by this subsection, the quality assurance assessment shall only be collected and expended if Medicaid hospital inpatient DRG and outpatient reimbursement rates and disproportionate share hospital and graduate medical education payments are not below the level of rates and payments in effect on April 1, 2002 as a direct result of the quality assurance

> assessment collected under subsection (1)(h), except as provided in subdivision (h).
>
> (h) The quality assurance assessment collected under subsection (1)(h) shall not be assessed or collected after September 30, 2011 if the quality assurance assessment is not eligible for federal matching funds. Any portion of the quality assurance assessment collected from a hospital that is not eligible for federal matching funds shall be returned to the hospital.
>
> (i) The state retention amount of the quality assurance assessment collected under subsection (1)(h) shall be equal to 13.2% of the federal funds generated by the hospital quality assurance assessment, including the state retention amount. The 13.2% state retention amount described in this subdivision does not apply to the Healthy Michigan plan. In the fiscal year ending September 30, 2016, there is a 1-time additional retention amount of up to $92,856,100.00. Beginning in the fiscal year ending September 30, 2017, and for each fiscal year thereafter, there is a retention amount of $105,000,000.00 for each fiscal year for the Healthy Michigan plan. The state retention percentage shall be applied proportionately to each hospital quality assurance assessment program to determine the retention amount for each program. The state retention amount shall be appropriated each fiscal year to the department to support Medicaid expenditures for hospital services and therapy. These funds shall offset an identical amount of general fund/general purpose revenue originally appropriated for that purpose. By May 31, 2019, the department, the state budget office, and the Michigan Health and Hospital Association shall identify an appropriate retention amount for the fiscal year ending September 30, 2020 and each fiscal year thereafter.
>
> * * *
>
> (14) The quality assurance assessment provided for under this section is a tax that is levied on a health facility or agency.

MICH. COMP. LAWS § 333.20161 (June 8, 2018 to Sept. 29, 2019)[21] revised the statute to change the word "shall" to "must" throughout, and as follows, *where italics indicate new language*:

> (12) The quality assurance dedication is an earmarked assessment collected under subsection (1)(h). That assessment and all federal matching funds attributed to that

[21] A revision to the law effective Sept. 30, 2019 – the final day of the period relevant to this hearing – primarily revises license fees but does not revise Sections 1, 10, 12 or 14. *See* 2019 Mich. Legis. Serv. P.A. 74 (S.B. 444).

assessment *must* be used only for the following purpose and under the following specific circumstances:

* * *

(i) The state retention amount of the quality assurance assessment collected under subsection (1)(h) *must* be equal to 13.2% of the federal funds generated by the hospital quality assurance assessment, including the state retention amount. The 13.2% state retention amount described in this subdivision does not apply to the Healthy Michigan plan. In the fiscal year ending September 30, 2016, there is a 1-time additional retention amount of up to $92,856,100.00. *In* the fiscal year ending September 30, 2017, there is a retention amount of $105,000,000.00 for the Healthy Michigan plan. Beginning in the fiscal year ending *September 30, 2018, and for each fiscal year thereafter, there is a retention amount of $118,420,600.00 for each fiscal year for the Healthy Michigan Plan.* The state retention percentage *must* be applied proportionately to each hospital quality assurance assessment program to determine the retention amount for each program. The state retention amount *must* be appropriated each fiscal year to the department to support Medicaid expenditures for hospital services and therapy. These funds *must* offset an identical amount of general fund/general purpose revenue originally appropriated for that purpose. By May 31, 2019, the department, the state budget office, and the Michigan Health and Hospital Association shall identify an appropriate retention amount for the fiscal year ending September 30, 2020 and each fiscal year thereafter.

B. MEDICARE PROGRAM

As noted, *supra*, St. Francis is a critical access hospital and, therefore, is reimbursed at 101 percent of its reasonable costs of providing inpatient services to Medicare patients,[22] including all years at issue in this appeal. The statutory provisions addressing Medicare reasonable cost reimbursement are located in 42 U.S.C. § 1395x(v)(l)(A). In pertinent part, the statute provides:

> The reasonable cost of any services shall be the cost actually incurred, excluding therefrom any part of incurred cost 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, in determining such costs for various types or classes of institutions, agencies, and services. . . .

The regulations implementing this statutory provision are located at 42 C.F.R. § 413.9, "Cost related to patient care", and state:

[22] 42 C.F.R. § 413.70 (2014).

(a) Principle. All payments to providers of services must be based on the reasonable cost of services covered under Medicare and related to the care of beneficiaries. Reasonable cost includes all necessary and proper costs incurred in furnishing the services, subject to principles relating to specific items of revenue and cost. However, for cost reporting periods beginning after December 31, 1973, payments to providers of services are based on the lesser of the reasonable cost of services covered under Medicare and furnished to program beneficiaries or the customary charges to the general public for such services, as provided for in § 413.13.

(b) Definitions-

> (1) Reasonable cost. Reasonable cost of any services must be determined in accordance with regulations establishing the method or methods to be used, and the items to be included. The regulations in this part take into account both direct and indirect costs of providers of services. The objective is that under the methods of determining costs, the costs with respect to individuals covered by the program will not be borne by individuals not so covered, and the costs with respect to individuals not so covered will not be borne by the program. These regulations also provide for the making of suitable retroactive adjustments after the provider has submitted fiscal and statistical reports. The retroactive adjustment will represent the difference between the amount received by the provider during the year for covered services from both Medicare and the beneficiaries and the amount determined in accordance with an accepted method of cost apportionment to be the actual cost of services furnished to beneficiaries during the year.
>
> (2) Necessary and proper costs. Necessary and proper costs are costs that are appropriate and helpful in developing and maintaining the operation of patient care facilities and activities. They are usually costs that are common and accepted occurrences in the field of the provider's activity.

(c) Application.

> (1) It is the intent of Medicare that payments to providers of services should be fair to the providers, to the contributors to the Medicare trust funds, and to other patients.
>
> (2) The costs of providers' services vary from one provider to another and the variations generally reflect differences in scope of services and intensity of care. The provision in Medicare for payment of reasonable cost of services is intended to meet the

> actual costs, however widely they may vary from one institution to another. This is subject to a limitation if a particular institution's costs are found to be substantially out of line with other institutions in the same area that are similar in size, scope of services, utilization, and other relevant factors.
>
> (3) The determination of reasonable cost of services must be based on cost related to the care of Medicare beneficiaries. Reasonable cost includes all necessary and proper expenses incurred in furnishing services, such as administrative costs, maintenance costs, and premium payments for employee health and pension plans. It includes both direct and indirect costs and normal standby costs. However, if the provider's operating costs include amounts not related to patient care, specifically not reimbursable under the program, or flowing from the provision of luxury items or services (that is, those items or services substantially in excess of or more expensive than those generally considered necessary for the provision of needed health services), such amounts will not be allowable. The reasonable cost basis of reimbursement contemplates that the providers of services would be reimbursed the *actual costs* of providing quality care however widely the actual costs may vary from provider to provider and from time to time for the same provider. [23]

In making a determination as to what constitutes a reasonable cost, the regulations at 42 C.F.R. § 413.98 state:

> (a) Principle. Discounts and allowances received on purchases of goods or services are reductions of the costs to which they relate. Similarly, refunds of previous expense payments are reductions of the related expense.
>
> (b) Definitions—
>
> > (1) Discounts. Discounts, in general, are reductions granted for the settlement of debts.
> >
> > (2) Allowances. Allowances are deductions granted for damage, delay, shortage, imperfection, or other causes, excluding discounts and returns.
> >
> > (3) Refunds. Refunds are amounts paid back or a credit allowed on account of an overcollection.

[23] (Emphasis added.)

> (c) Normal accounting treatment-Reduction of costs. All discounts, allowances, and refunds of expenses are reductions in the cost of goods or services purchased and are not income. If they are received in the same accounting period in which the purchases were made or expenses were incurred, they will reduce the purchases or expenses of that period. However, if they are received in a later accounting period, they will reduce the comparable purchases or expenses in the period in which they are received.
>
> (d) Application.
>
> > (1) Purchase discounts have been classified as cash, trade, or quantity discounts. Cash discounts are reductions granted for the settlement of debts before they are due. Trade discounts are reductions from list prices granted to a class of customers before consideration of credit terms. Quantity discounts are reductions from list prices granted because of the size of individual or aggregate purchase transactions. Whatever the classification of purchase discounts, like treatment in reducing allowable costs is required. In the past, purchase discounts were considered as financial management income. However, modern accounting theory holds that income is not derived from a purchase but rather from a sale or an exchange and that purchase discounts are reductions in the cost of whatever was purchased. The true cost of the goods or services is the net amount actually paid for them. Treating purchase discounts as income would result in an overstatement of costs to the extent of the discount.
> >
> > (2) As with discounts, allowances, and rebates received from purchases of goods or services, refunds of previous expense payments are clearly reductions in costs and must be reflected in the determination of allowable costs. This treatment is equitable and is in accord with that generally followed by other governmental programs and third-party payment organizations paying on the basis of cost.

C. PROVIDER REIMBURSEMENT MANUAL

Provider Reimbursement Manual, CMS Pub. 15-1 ("PRM 15-1") § 2122 provides Medicare guidance on the circumstances under which taxes paid by a provider are considered allowable reasonable costs:

> 2122.1 General Rule.--The general rule is that taxes assessed against the provider, in accordance with the levying enactments of the several States and lower levels of government and for which

the provider is liable for payment, are allowable costs. Tax expense should not include fines and penalties. *Taxes are allowable costs **to the extent** they are actually incurred **and** related to the care of beneficiaries.*

Whenever exemptions to taxes are legally available, the provider is expected to take advantage of them. If the provider does not take advantage of available exemptions, the expenses incurred for such taxes are not recognized as allowable costs under the program.

2122.2 Taxes Not Allowable as Costs.--Certain taxes which are levied on providers are ***not*** allowable costs. These taxes include:

A. Federal income and excess profit taxes, including any interest or penalties paid thereon (see § 1217).

B. State or local income and excess profit taxes (see § 1217).

C. Taxes in connection with financing, refinancing, or refunding operations, such as taxes on the issuance of bonds, property transfers, issuance or transfer of stocks, etc. Generally, these costs are either amortized over the life of the securities or depreciated over the life of the asset. They are not, however, recognized as tax expense.

D. Taxes from which exemptions are available to the provider.

E. Special assessments on land which represent capital improvements such as sewers, water, and pavements should be capitalized and depreciated over their estimated useful lives.

F. Taxes on property which is not used in the rendition of covered services.

G. Taxes, such as sales taxes, levied against the patient and collected and remitted by the provider.

H. Self-employment (FICA) taxes applicable to individual proprietors, partners, members of a joint venture, etc.

* * *

2122.7 Review of Reasonable Costs, Including Taxes. -- In general, reasonable costs claimed by a provider, including taxes, must be actually incurred. While a tax may fall under a category that is generally accepted as an allowable Medicare cost, the provider may only treat the net tax expense as the reasonable cost

> actually incurred for Medicare payment purposes. ***The net tax expense is the tax paid by the provider, reduced by payments the provider received that are associated with the assessed tax.*** Contractors will continue to determine whether taxes and other expenses are allowable based on reasonable cost principles set forth in the Medicare statute and regulations. [24]

The following statements in the preamble to the FY 2011 IPPS Final Rule[25] were the basis for the addition of § 2122.7 (as stated, *supra*) to the PRM 15-1 in December 2011:

> In the FY 2011 IPPS/LTCH PPS proposed rule (75 FR 24019), we stated that we have learned that there is some confusion relating to the determination of whether a tax is an allowable cost. We believe that much of this confusion has arisen because it may be possible to read sections 2122.1 and 2122.2 of the PRM–1 as permitting all taxes assessed on a provider by a State that are not specifically listed in section 2122.2 to be treated as allowable costs. Section 2122 of the PRM–1 was last updated in 1979 when States typically raised revenue only from income, sales, and property taxes. The list in section 2212.2 is incomplete now, as it does not reflect the variety of provider taxes imposed by States. *In addition, we are concerned that, even if a particular tax may be an allowable cost that is related to the care of Medicare beneficiaries, providers may not, in fact, "incur" the entire amount of these assessed taxes. For example, in accordance with the Medicaid statute and regulations, some States levy tax assessments on hospitals. The assessed taxes may be paid by the hospitals into a fund that includes all taxes paid, all Federal matching monies, and any penalties for nonpayment. The State is then authorized to disburse monies from the fund to the hospitals. We believe that these types of subsequent disbursements to providers are associated with the assessed taxes and may, in fact, offset some, if not all, of the taxes originally paid by the hospitals*.
>
> We believe that the treatment of these types of payments on the Medicare cost report should be analogous to the adjustments described at § 413.98 of the regulations. Specifically, § 413.98(d) provides that the "true cost of the goods or services is the net amount actually paid for them." Section 413.98 specifically addresses the purchase of goods and services and reflects the statutory mandate that a provider's allowable costs are the net expenses it incurs for items and services. ***In situations in which payments that are associated with the assessed tax are made to providers specifically to make the provider whole or partly whole***

[24] (Bold and italics emphasis added.)
[25] 75 Fed. Reg. 50042 (Aug. 16, 2010).

***for the tax expenses**, Medicare should similarly recognize only the **net** expense incurred by the provider. Thus, while a tax may be an allowable Medicare cost in that it is related to beneficiary care, the provider may only treat as a reasonable cost the **net** tax expense; **that is, the tax paid by the provider, reduced by payments the provider received that are associated with the assessed tax**.*

***

Therefore, we proposed to clarify the policy set forth in sections 2122.1 and 2122.2 of the PRM–1 to reflect our concerns set forth above regarding when certain provider taxes may be allowable costs under the Medicare program.

***

We believe that this provision, as articulated in the proposed rule, is a clarification of our current, longstanding policy which requires that "reasonable costs" claimed by providers must be "actually incurred." Currently, CMS and its Medicare contractors apply the longstanding reasonable cost principles at section 1861(v)(1)(A) of the Act and at 42 CFR 413.9 of the regulations to determine if a particular expense is an allowable cost under Medicare. One such principle, as discussed above, is that a ''reasonable cost'' must be "actually incurred."

We disagree that sections 2122.1 and 2122.2 of the PRM–1 take a contrary position. The discussion of taxes and allowable costs in the PRM–1 does not specifically address the requirement that costs must be "actually incurred." However, the discussion of provider taxes in the PRM–1 should be considered in conjunction with the reasonable costs requirements set forth in the statute and regulations. To the extent that providers considered the list in section 2122.2 of the PRM–1 to permit a facility from counting, as part of its allowable costs, all but the listed provider taxes, regardless of whether the taxes listed were "actually incurred," we are now clarifying that this approach is inconsistent with reasonable cost principles.

We believe that it is consistent with the current and longstanding principles of cost reimbursement, as set forth in the statute and regulations, to remind both providers and our contractors, that although a particular tax may be an allowable cost, the amount of that tax that providers may claim for reasonable cost purposes, must reflect the amount of these assessed taxes that are actually incurred. Thus, in accordance with the Medicare statute,

> regulations, and PRM policies, Medicare contractors will continue to apply the current reasonable cost principles to determine if a provider tax incurred is an allowable cost and how much of that allowable cost is actually incurred to determine reimbursement.
>
> As stated in the proposed rule, we intended to address the potential confusion that arises when providers interpret sections of the PRM–1 to allow taxes assessed against a provider that are not specifically listed in section 2122.2, regardless of whether those costs are actually incurred. We believe that clarifying the PRM–1 to explain that the list of taxes is only an example of the enumerated taxes is consistent with the current and longstanding reasonable cost principles. Moreover, to the extent that a particular tax might be an allowable expense, it still must be "actually incurred."
>
> This clarification will not have an effect of disallowing any particular tax but rather make clear that our Medicare contractors will continue to make a determination of whether a provider tax is allowable, on a case-by-case basis, using our current and longstanding reasonable cost principles. *In addition, the Medicare contractors will continue to determine if an adjustment to the amount of allowable provider taxes is warranted to account for payments a provider receives that are associated with the assessed tax*.
>
> After consideration of the public comments we received, we are adopting our proposed clarification, as final, without modification. ***We will modify section 2122 of the PRM–1 to specifically reference our current, longstanding reasonable cost principles***.[26]

In December 2011, CMS added § 2122.7 to PRM 15-1 § 2122[27] in accordance with the CMS policy contained in the FY 2011 IPPS Final Rule.

D. STANDARD OF REVIEW AND BURDEN OF PROOF

A Board decision must include findings of fact and conclusions of law that "the provider carried its burden of production of evidence and burden of proof by establishing, by a preponderance of the evidence, that the provider is entitled to relief on the merits of the matter at issue."[28]

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[26] *Id.* at 50362-64 (emphasis added).

[27] PRM 15-1, Transmittal 448 (Dec. 2011) (stating "Section 2122 is revised in accordance with the FY 2011 IPPS Final Rule, published on August 16, 2010, which clarified policy with respect to the treatment of the taxes incurred by providers and reported on the Medicare cost report. This clarification is consistent with the current and longstanding statutory, regulatory, and policy provisions.") (*available at* https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R448PR1.pdf) (*last accessed* Jun., 25, 2026).

[28] 42 C.F.R. § 405.1871(a)(3).

Additionally, "[a] decision by the Board shall be based upon the record made at such hearing, which shall include the evidence considered by the [Medicare contractor] and such other evidence as may be obtained or received by the Board, and shall be supported by substantial evidence when the record is viewed as a whole."[29] In *Consolidated Edison Co. v. NLRB*, 305 U.S. 197, 229 (1938), the U.S. Supreme Court held, "[s]ubstantial evidence is more than a mere scintilla. It means such relevant evidence as a reasonable mind might accept as adequate to support a conclusion."[30] Accordingly, in an appeal before the Board, a provider must prove by a preponderance of substantial, relevant evidence that it is entitled to the relief sought. Further, the "Board shall afford great weight to interpretative rules, general statements of policy, and rules of agency organization, procedure, or practice established by CMS."[31]

DISCUSSION, FINDINGS OF FACT, AND CONCLUSIONS OF LAW:

St. Francis seeks to claim as an allowable cost the portion of its Michigan QAAP tax that was retained by the state to offset general purpose funds.[32] First, St. Francis contends that the "retention amount is not associated with or related to supplemental Medicaid payments the Provider received from the QAAP payment pool."[33] Furthermore, St. Francis articulates its rationale for asserting that the Medicare Contractor incorrectly offset the retention amounts with payments it received from the QAAP payment pool, as follows:

> The MAC's decision was predicated on the notion that the retention amount St. Francis paid must be related to the QAAP payments St. Francis received because the former is collected at the same time as the payment pool component that funded those payments, and the retention amount, the payment pool component and the QAAP payments are all described in the same part of the Michigan code.[34]

St. Francis makes several arguments in its post-hearing brief related to the various supplemental payment programs established by the State of Michigan. They argue that "[t]hese programs are 100 percent financed by a provider tax known as the Quality Assurance Assessment Program ("QAAP")" and that "the statute authorizing the QAAP also requires MDHHS to implement another assessment known as the retention amount."[35] St. Francis further argues that the tax expense it claimed on the cost reports in question is only attributable to the retention amount.[36] Further, its witness at the hearing, who was involved in the calculation of the taxes at the state level, testified that "the proceeds of the retention amount assessments did NOT fund the

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[29] 42 U.S.C. § 1395oo(d). This statutory provision also confirms that: "[t]he Board shall have the power to affirm, modify, or reverse a final determination of the fiscal intermediary with respect to a cost report and to make any other revisions on matters covered by such cost report (including revisions adverse to the provider of services) even though such matters were not considered by the intermediary in making such final determination." *See also* 42 C.F.R. § 405.1869(a).
[30] *See also Pomona Valley Hosp. Med. Ctr. v. Becerra*, 82 F.4th 1252, 1258-59 (D.C. Cir. 2023).
[31] 42 C.F.R. § 405.1867.
[32] Provider's Revised Consolidated Final Position Paper at 7.
[33] *Id.* at 8.
[34] *Id.* at 7-8.
[35] Provider's Consolidated Post-Hearing Brief at 2 (Aug. 5, 2024).
[36] *Id.*

supplemental payments authorized under the QAAP."[37] St. Francis further asserts that the Michigan QAAP statute forbids using the proceeds of the retention amount assessment to fund the supplemental payments authorized under the QAAP statue."[38] Because the retention assessment "did NOT fund the supplemental payments authorized under the QAAP", they are not "associated with" one another, and thus any supplemental payments received should not have been offset against the retention amounts.[39]

St. Francis' witness provided testimony at the hearing regarding the calculation, on an aggregate basis, of the total amount the State of Michigan would assess providers under the QAAP to fund the supplemental payments.[40] The state/non-federal share of dollars that the State of Michigan was committed to spend in order to generate the federal matching dollars to fund the total payments was added to the federal match to result in the total to fund the supplemental payments.[41] In this instance, the non-federal share was provided by a tax assessed on hospitals.[42]

St. Francis explains that the combination of the aggregate QAAP to Support Payment and the aggregate retention assessment result in the total QAAP assessment.[43] The Total QAAP assessment is divided among all Michigan hospitals "based on their proportionate share of net revenue (excluding Medicare)."[44] MDHHS would then issue individual bills to each Michigan hospital reflecting their proportionate share of the total QAAP, including their proportionate shares of the QAAP to Support Payment and the retention amount assessment.[45] At the end of each state fiscal year, MDHHS issues a letter "to inform Michigan hospitals the percentage of their Total QAAP assessments that were attributable to the retention assessment."[46]

In its Consolidated Optional Response to the Medicare Contractor's Final Position Paper, the Provider refutes the Medicare Contractor's assertion that the retention component exists to pay for the overhead cost of the QAAP tax, stating that "nothing in the statute suggests that the purpose of the retention component is to pay for the administrative costs of the QAAP fund."[47] The Provider further argues that "the statute says that the retention component is used for two different purposes. First, it is used to offset funds that would have otherwise been drawn from the state to pay for hospital services and therapy to Medicaid beneficiaries . . . . Second, the retention amount provides funding for the Healthy Michigan plan, which is a section 1115 waiver that was in effect during the cost reporting periods under appeal."[48]

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[37] *Id.*
[38] *Id*.
[39] *Id*. at 2-3.
[40] *Id*. at 7 (citing Tr. at 49).
[41] *Id*.
[42] *Id.* at 8 and Exhibit P-11 at 6.
[43] *See* Provider's Consolidated Post-Hearing Brief at 11.
[44] *Id*.
[45] *Id*.
[46] *Id.* (citing Tr. at 92-96); *see also* Exhibit P-11 at 6.
[47] Provider's Consolidated Optional Response at 2-3 (Mar. 19, 2024).
[48] *Id*. at 3.

St. Francis then attests that the retention component is a "net loss" for the Provider[49] and refutes the Medicare Contactor's claim that it "was a net winner due to the QAAP, as it received disbursements from the QAAP fund that exceeded the taxes it was assessed and paid into the QAAP fund."[50] St. Francis argues that even if the "net winner" statement were true, "the retention component would still be a net loss for the Provider. This is because instead of receiving reimbursement the Provider is otherwise owed by the state for 'hospital services and therapy,' the Provider instead pays itself for those services through the retention component of the tax."[51]

Next, St. Francis disagrees that it failed to respond to the MAC's request for information.[52] The Provider argues that its "responses included citations to the parts of the Provider's position paper that directly answered many of the MAC's questions."[53] St. Francis admits that were several questions that it "expressly declined to answer."[54] It also refused to disclose the total amount of QAAP payments it received because it believes they are irrelevant to this appeal but acknowledged that "the QAAP payments the provider received during that cost reporting period exceeded the total QAAP taxes that were paid."[55]

St. Francis also disagrees with the MAC's contention that, since the retention component "must equal 13.2% of the federal funds generated by the hospital quality assurance tax", the retention component is generated by those federal funds.[56] Instead, the Provider believes that the percentage is "simply the starting point for the retention component, because that amount is supplemented by an amount for the Health Michigan Plan."[57]

Finally, St. Francis contends that the cases cited by the Medicare Contractor do not support its "decision to offset the amount of the QAAP tax by the payments the Provider received from the QAAP payment pool."[58] The Provider believes the issues in these cases are different and states that "none of these cases stand for the for the proposition that the CMS can offset a tax expense by payments that were not funded by the tax."[59] Further, St. Francis contends that "CMS's briefing in *Dana-Farber* and *Breckenridge* suggest that offset is warranted only to the extent that hospitals receive payments *funded by* the proceeds of the very tax they are claiming for reimbursement."[60]

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[49] *Id.*
[50] Case No. 22-0852, Medicare Contractor's Final Position Paper at 10 (Feb. 5, 2024).
[51] Provider's Consolidated Optional Response at 4.
[52] *Id*.
[53] *Id*.
[54] *Id*.
[55] *Id*. at 5.
[56] *Id*.
[57] *Id*. at 5 – 6.
[58] *Id*. at 6, *referring to Dana-Farber Cancer Institute v. Hargan,* 878 F.3d 336, *Breckenridge Health, Inc. v. Price,* 869 F.3d 422, *Abraham Lincoln Memorial Hospital v. Sebelius*, 698 F.3d 536 (7th Cir. 2012), and *Kindred Hospitals East, LLC v. Sebelius*, 694 F.3d 924 (8th Cir. 2012). *See also* Provider's Revised Consolidated Final Position Paper at 11-14.
[59] Provider's Revised Consolidated Final Position Paper at 14.
[60] *Id.* at 15.

St. Francis maintains that "The QAAP Statute Prohibits Using the Retention Amount Assessment to Fund the Supplemental Payments Authorized under the QAAP."[61] It contends that "[t]he fact that the retention amount assessment must be used to replace general fund/general purpose revenues means, both as a matter of fact and a matter of law, that the retention amounts are not in any way funding supplemental payments under the supplemental payment programs authorized under the QAAP statute."[62]

The Medicare Contractor claims "[t]he Provider's argument is straightforward, simple, and wrong."[63] It argues that St. Francis used the State of Michigan's defined retained percentages of the funds collected from all hospitals to apply to each hospital's QAAP tax payments to derive a retained portion of the taxes the hospital paid..[64] In fiscal year 2017, St. Francis claims that the State of Michigan retained 35.2 percent of the QAAP taxes collected.[65] Therefore, St. Francis argues that it is entitled to claim 35.2 percent of the provider taxes it paid- $785,503 – instead of offsetting their receipts from the QAAP against the amount paid.[66] The Medicare Contractor asserts that St. Francis "ignores one of the basic principles of Medicare reimbursement," . . . [c]osts must be actually incurred to qualify for Medicare reimbursement."[67] Additionally, the Medicare Contractor asserts that St. Francis has not disclosed the exact amount retained by the State of Michigan and instead relies on the aggregate percentage from all providers throughout the state.[68]

The Medicare Contractor notes that *St. Francis has acknowledged "that it ultimately received more from the State of Michigan than it paid in QAAP taxes*."[69] The Medicare Contractor points out that – contrary to St. Francis's contention that the portion it is a claiming is a separate retention tax – Michigan's statutes state:

> [T]he quality assurance assessment collected…must not be assessed or collected after September 30, 2011 if the quality assurance assessment is not eligible for federal matching funds. Any portion of the quality assurance assessment collected from a hospital that is not eligible for federal matching funds must be returned to the hospital.[70]

Thus, the Medicare Contractor notes, hospitals not eligible for federal matching funds do not pay the QAAP tax, which must be "netted out" against the State payments.[71]

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[61] Provider's Consolidated Post-Hearing Brief at 12 (capitalization in the original).
[62] *Id.* at 13.
[63] Medicare Contractor's Post Hearing Brief (August 5, 2024) at 5.
[64] *See* Case No. 20-0514, Medicare Contractor's Final Position Paper at 10 (February 5, 2024).
[65] *See* Medicare Contractor's Post Hearing Brief at 5.
[66] *See id.* at 5.
[67] Case No. 20-0514, Medicare Contractor's Final Position Paper at 10.
[68] *See* Medicare Contractor's Consolidated Post Hearing Brief at 5.
[69] Medicare Contractor's Post Hearing Brief at 5. *See also,* Provider Consolidated Post Hearing Brief at 3 wherein the Provider states ***"Further, because provider taxes are used to draw down matching federal dollars – and the FMAP in Michigan is well over 50 percent – the amount of payments will always exceed the amount of taxes paid, whether it is the tax that funds the support payments, the retention amount assessment or the sum of the two."***
[70] Medicare Contractor's Post Hearing Brief at 6, *citing* MICH. COMP. LAWS 333.20161(12)(h).
[71] *See* Medicare Contractor's Post Hearing Brief at 6.

The Medicare Contractor claims that St. Francis' witness at the hearing admitted that "the general fund/general purpose retention . . . is replenished only for those amounts that the State spent on hospital therapy and hospital services."[72] The Medicare Contractor contends that this implies that State "the tax and the payments are associated with one another . . . and must be netted against one another."[73]

The Medicare Contractor's overarching concern is that St. Francis "has not disclosed the actual amount of the distributions it received from the QAAP program,"[74] failing to comply with 42 C.F.R. § 413.20 and 413.24.[75] As a result, the Medicare Contractor concludes that St. Francis has not shown evidence to support the reimbursement of the costs denied by the Medicare Contractor at final settlement. The Medicare Contractor maintains that St. Francis has not met its burden of proof.[76]

Furthermore, the Medicare Contractor asserts that neither the Provider's exhibits nor the testimony at hearing specify the amount retained from the QAAP tax paid by this Provider, further the Provider's case relies on a generalized letter from the State of Michigan, and, ultimately the record does not reconcile the amounts paid with the amounts claimed.[77] The Medicare Contractor asserts that it was unable to determine the net tax expense (the QAAP taxes paid by the Provider less the QAAP payments the Provider received) due to a lack of documentation.[78]

The key question in these appeals is whether St. Francis "actually incurred" the Michigan QAAP Tax paid, as defined in the governing Medicare regulations and guidance. The Board finds that the provisions at 42 U.S.C. § 1395x(v)(1)(A) and 42 C.F.R. § 413.9, which govern reasonable cost reimbursement, are the controlling authorities in these appeals. These authorities require that the "reasonable cost of any services shall be the *cost* ***actually*** *incurred*, excluding therefrom any part of incurred cost found to be unnecessary in the efficient delivery of needed health services."[79] Likewise, the regulation states, in pertinent part, that "the reasonable cost basis of reimbursement contemplates that the providers of services would be reimbursed the ***actual*** *costs* of providing quality care however widely the actual costs may vary from provider to provider and from time to time for the same provider."[80]

Consistent with these authorities, PRM 15-1 § 2122.1 specifies that "[t]axes are allowable costs to the extent they are ***actually*** *incurred* and related to the care of beneficiaries."[81] In determining the cost "actually incurred" or "true cost," 42 C.F.R. § 413.98 and PRM 15-1 §§ 800 and 804 require that a provider's costs be offset to account for the receipt of refunds, rebates, credits or

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[72] *Id.* at 6-7, *referring to* Tr. at 108-109.
[73] *Id.* at 7.
[74] Case No. 20-0514, Medicare Contractor's Final Position Paper at 14.
[75] *See id.*
[76] *See id.*
[77] *See* Medicare Contractor's Post Hearing Brief at 7.
[78] *See* Medicare Contractor's Final Position Paper case number 20-0514 at page 16.
[79] 42 U.S.C. § 1395x(v)(1)(A) (emphasis added).
[80] 42 C.F.R. § 413.9(c)(3) (Emphasis added).
[81] (Emphasis added.)

other discounts by offsetting the costs to which they relate. In particular, PRM 15-1 § 800 specifies that "refunds of previous expense payments are reductions of the related expense."

Finally, the clarification to PRM 15-1 *§* 2122 in accordance with the clarification to CMS policy which was contained in the FY 2011 Inpatient Prospective Payment System ("IPPS") Final Rule published on August 16, 2010 ("FY 2011 IPPS Final Rule") at § 2122.7 addresses the very issue in these cases stating "***[w]hile a tax may fall under a category that is generally accepted as an allowable Medicare cost, the provider may only treat the net tax expense as the reasonable cost actually incurred for Medicare payment purposes. The net tax expense is the tax paid by the provider, reduced by the payments the provider received that are associated with the assessed tax.***"[82]

The Board finds that St. Francis did not supply sufficient documentary evidence in these appeals to support the amounts of the QAAP taxes paid or revenues received to properly calculate its ***net tax expense*** as defined by the regulations. St. Francis spent considerable effort both in its position papers and in witness testimony at the hearing describing the calculation of the QAAP taxes at an aggregate basis across all Michigan providers. Unfortunately, minimal effort was made to gather documentation specific to St. Francis' taxes or revenues.

The only documentation in the record to support the QAAP taxes paid by St. Francis is an excerpt from the hospital's trial balance for Account 708301-88500 – Medicaid Fees, showing the total QAAP taxes paid each fiscal year.[83] St. Francis did not supply invoices to support that trial balance account.[84] Additionally, St. Francis did not supply any documentation to support the QAAP payments that it received, despite requests from the Medicare Contractor as noted in the Medicare Contractor's witness testimony.

At the hearing, the Provider's witness testified to the existence of such documentation:

> MAC Rep: So in addition to P-4, providers get a quarterly bill from the state saying, this is your tax bill under QAAP, correct?
>
> Provider Witness: Well, they get a quarterly bill for the QAAP related to each program. So it could add to 15-16 bills throughout the year-ish.
>
> MAC Rep: And they get a quarterly statement saying, this is how much money you're getting from the QAAP program. And they get that, I believe your testimony was a couple of days before they get the bill. Right?

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[82] (Emphasis added.)

[83] *See e.g.,* Case No. 20-0514 MAC FPP Ex. C-2 at C-0006.

[84] Indeed, PRM 15-1 § 2122.1 states that Tax Expense should not include fines and penalties. Board Member Smith made the following inquiry of the Medicare Contractor witness at the hearing:

> Mr. Smith: And because we don't have any of the invoices, we cannot reconcile this $2.23154 million for this provider to guarantee that it only contains the provider tax, that some error wasn't made in the accounting to prove to put some other tax in there by accident, that any penalty fees are in there. We have no proof of what makes that up.
>
> Medicare Contractor's Witness: That is correct. (Tr. at 246-247)

Provider Witness: I know I didn't say a couple of days. It could be generally beforehand, but it could be, it could vary between 10 to 15 days, depending.
MAC Rep: So on day X they get a, the provider gets a statement that says you're receiving Y dollars, and on day X plus a certain number
of days they get a bill saying, please remit to us Z dollars. Correct?
Provider Witness: I'm not exactly sure how they're informed of the exact amount. I know that's what I know. The amounts that would get transferred to them. But the information would come through on their, whatever forms are used to process payments.
MAC Rep: But you'd acknowledge that providers would have to get something telling them how much they have to pay into the QAAP program. Correct? Otherwise, they wouldn't know how much to pay.
Provider Witness: Yes. They get invoices for that. Yes.
MAC Rep: And we don't have those invoices in the records here. We have a letter from the State of Michigan saying the retention amount is 34.7 percent of the fiscal year '19 hospital Quality Assurance Assessment. Correct?
Provider Witness: To best my knowledge, yes.[85]

The testimony indicates that documentation existed that would have allowed the Medicare Contractor to verify St. Francis' ***net tax expense***. However, St. Francis did not submit this documentation into the record in these appeals.

As a CAH, St. Francis is subject to the Medicare regulations governing reasonable cost reimbursement in 42 C.F.R. Part 413 that specify certain cost reporting and record keeping requirements. In particular, 42 C.F.R. § 413.24(c) requires that "data be accurate and in sufficient detail to accomplish the purposes for which it is intended." Similarly, CMS' implementing manual guidance in the Provider Reimbursement Manual, CMS Pub. No. 15-1 (PRM 15-1) § 2304 requires that: "[c]ost information as developed by the provider must be current, accurate and in sufficient detail to support payments made for services rendered to beneficiaries." With regard to its ***net tax expense***, St. Francis did not meet the requirement.

The Board also finds that St. Francis has not explained how the Michigan QAAP statute aligns with its claim that "[b]ecause the retention amount assessment did not (and by law, could not) 'fund' the supplemental payments authorized under the QAAP, they are not "associated with" one another."[86] It is St. Francis' contention that this leads to the conclusion that any supplemental payments received should not have been offset against the retention amounts.[87] The Board points to MICH. COMP. LAWS § 333.20161(12)(h) which states the following:

[85] Tr. at 169-171.
[86] Provider's Consolidated Post-Hearing Brief at 4-5.
[87] *Id.* at 5.

> The quality assurance assessment collected under subsection (1)(h) must not be assessed or collected after September 30, 2011 if the quality assurance assessment is not eligible for federal matching funds. Any portion of the quality assurance assessment collected from a hospital that is not eligible for federal matching funds must be returned to the hospital.

The statute clearly states that funds not eligible for federal matching funds must be returned to the hospital. If the retention assessment did not pull down federal matching dollars, it should have been returned to the hospital. Since it was not returned to the hospital, the Board must assume that the retention assessment was used to pull down federal matching dollars which funded both supplemental payments and the retention amount. This necessarily means the entire tax (both the "QAAP to Support Payment" assessment and the retention assessment) should be compared to the supplemental payments received to calculate ***net tax expense***. As St. Francis has acknowledged that it received more in QAAP payments than it paid in QAAP taxes, the Medicare Contractor's offset of St. Francis' entire QAAP Tax expense was justified.

DECISION:

After considering Medicare law and regulations, the arguments presented, and the evidence admitted, the Provider Reimbursement Review Board ("Board") finds that the Medicare Contractor properly removed the entire Quality Assurance Assessment Program ("QAAP") tax paid by the Provider in Fiscal Years 2017 through 2019, as there was no evidence to support the QAAP tax paid or the QAAP payments received to calculate "net tax expense" as defined by the regulations.

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FOR THE BOARD:

7/9/2026

X Kevin D. Smith, CPA

Kevin D. Smith, CPA
Board Chair
Signed by: KEVIN D. SMITH -A