

**PROVIDER REIMBURSEMENT REVIEW BOARD
DECISION**

2026-D31

PROVIDER –
West Park Hospital District

PROVIDER NUMBER - 53-1312

vs.

MEDICARE CONTRACTOR –
Noridian Healthcare Solutions

RECORD HEARING DATE –
September 17, 2025

COST REPORTING PERIODS ENDED –
June 30, 2017, June 30, 2018, June 30, 2019,
June 30, 2020 & June 30, 2021

CASE NUMBERS – 20-0564, 21-0407,
22-0375, 23-0228 & 24-0631

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ISSUE STATEMENT:

Whether the Medicare Contractor properly calculated the Provider's Allowable Interest Costs.¹

DECISION:

After considering Medicare law, regulations, and program guidance, the arguments presented, and the evidence admitted, the Provider Reimbursement Review Board ("Board") finds that the Medicare Contractor properly calculated the Provider's allowable interest costs for fiscal years ("FYs") 2017, 2018, 2019, 2020, and 2021.

INTRODUCTION:

West Park Hospital District ("West Park" or "Provider"), which is also known and doing business as Cody Regional Health, is a designated critical access hospital ("CAH") located in Cody, Wyoming.² West Park's assigned Medicare contractor³ is Noridian Healthcare Solutions ("Medicare Contractor").⁴ West Park has several ownership interests, including an Ambulatory Surgical Center ("ASC") which is a separate corporate entity as well as a medical office building, Cathcart Health Center ("MOB"), which is located approximately two miles from West Park and includes various physician practices ("Cathcart Practices") that it owns and operates, which include urgent care, psychiatry, internal medicine, ENT/audiology, obstetrics/gynecology, and orthopedic services.⁵

The central dispute relates to adjustments made to West Park's allowable interest expense for FYs 2017, 2018, 2019, 2020, and 2021.⁶ On July 11, 2019, the Medicare Contractor issued a Notice of Program Reimbursement ("NPR") to West Park for FY 2017 which included an investment income offset on Worksheet A-8 which reduced West Park's interest expense.⁷ The Medicare Contractor made a similar adjustment to interest expense in West Park's FY 2018 NPR. For FYs 2019, 2020 and 2021, West Park included protested items for the issue on its

¹ Case No. 21-0407 (FYE 06/30/2018), Issue Statement at 1 (Dec. 22, 2020). *See also* Parties' Joint Stipulations ("Stip.") at III (C) which states: "rather, the parties dispute whether it is proper to include investment losses from the Cathcart Practices in the total investment income used to offset the allowable interest expense." (Aug. 29, 2025).

² Stip. at I (B) and I (C).

³ 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 relevant law may refer to FIs and MACs interchangeably, and the Board will use the term "Medicare contractor" to refer to both FIs and MACs, as appropriate and relevant.

⁴ Stip. at I (F).

⁵ *Id.* at I (D) and I (E); Provider's Final Position Paper ("Provider's FPP") at 1-2 and Exs. P-5 to P-9 (Apr. 30, 2025). Board notes that Provider's FPP refers to "five physician practices" and that Exs. P-5 and P-6, for 2017 and 2018, respectively, calculate operating losses for five practices (urgent care, psychiatry, internal medicine, ENT/audiology, and obstetrics/gynecology). Exs. P-7 to P-9, for 2019 through 2021, respectively, calculate losses for a sixth practice, orthopedic services.

⁶ Stip. at III (A).

⁷ Ex. C-1 at C0002-C0004 and Ex. C-2 at C0021.

Medicare Cost Reports, and the Medicare Contractor subsequently made adjustments in the applicable NPRs to eliminate the protested amounts in those years.⁸

Specifically, West Park seeks a recalculation of “the Provider’s net investment income for the purpose of offsetting interest expense when calculating the Provider’s Medicare reimbursement.”⁹ The Medicare Contractor’s FY 2017 and 2018 adjustments and its removal of the protested amounts for FYs 2019, 2020, and 2021 form the basis of West Park’s appeal.

West Park timely appealed the issues to the Board and met the jurisdictional requirements for a hearing. The Board approved a record hearing on September 17, 2025. West Park was represented by Daniel J. Hettich, Esq. of King & Spalding, LLP. The Medicare Contractor was represented by Joseph Bauers, Esq. of Federal Specialized Services.

STATEMENT OF RELEVANT FACTS:

Specifically, the Medicare Contractor and West Park disagree on the proper calculation of the investment income amount used as an offset of allowable interest expense.¹⁰ As previously stated, in FYs 2017 and 2018, the Medicare Contractor audited West Park’s records and made adjustments to revise the amount of total investment income to be offset against interest expense.¹¹ In FYs 2019, 2020 and 2021, West Park protested the issue on its submitted cost report, and the Medicare Contractor made adjustments to eliminate those protested amounts as part of its audit of those fiscal years.¹²

On August 29, 2025, the parties entered into joint stipulations indicating that the as-“claimed interest expense is correctly identified” in Provider’s Final Position Paper on Table A, Column A, but that the Medicare Contractor has not reviewed the costs in Column D, which West Park claims are the investment losses from the Cathcart Practices.¹³ Although the parties agree “that it is proper to include income from the ASC as investment income to be offset against [West Park’s] allowable interest expenses,”¹⁴ they disagree as to “whether it is proper to include *investment losses* from the Cathcart Practices in the total investment income used to offset the allowable interest expense.”¹⁵

⁸ Medicare Administrative Contractor’s Final Position Paper (hereinafter “Medicare Contractor’s FPP”) at 9 (May 27, 2025); Provider’s FPP at 3-4.

⁹ Provider’s FPP at 15.

¹⁰ Stip. at III (A).

¹¹ Ex. C-2 at C0021 and Ex. C-3 at C0037-0038.

¹² Ex. C-4 at C0058 and C0060, Ex. C-5 at C0072 and C0074, and Ex. C-6 at C0089.

¹³ Stip. at III (A), (C).

¹⁴ *Id.* at III (B).

¹⁵ *Id.* at III (C). (emphasis added).

As a result of the Medicare Contractor's adjustments and elimination of protested items, West Park's estimated amount in controversy, by year, is as follows:¹⁶

<u>Fiscal Year</u>	<u>Case No.</u>	<u>Estimated Amount in Controversy</u>
FYE 06/30/2017	20-0564	\$622,042
FYE 06/30/2018	21-0407	\$725,161
FYE 06/30/2019	22-0375	\$355,577
FYE 06/30/2020	23-0228	\$534,018
FYE 06/30/2021	24-0631	\$733,323

STATEMENT OF RELEVANT LAW:

The Medicare program was established under Title XVIII of the Social Security Act ("Act"), as amended, to provide health insurance to eligible individuals. Title XVIII of the Act was codified at 42 U.S.C. Chapter 7, Subchapter XVIII. The Centers for Medicare & Medicaid Services ("CMS") is the operating component of the Department of Health and Human Services ("DHHS") charged with administering the Medicare program.

Enacted as part of the 1965 Medicare legislation,¹⁷ § 1814(b) of the Act (codified at 42 U.S.C. § 1395f(h)) states that "[t]he amount paid to any provider of services with respect to services for which payment may be made under this part shall, subject to the provisions of section 1813, be the reasonable cost of such services, as determined under section 1861(v)."¹⁸ Further, as a result of this legislation, § 1861(v)(1) of the Act (codified at 42 U.S.C. § 1395x(v)(1)(A)) defines "reasonable cost"¹⁹ and, as subsequently revised, it defines that term as "the cost actually incurred, excluding therefrom any part of incurred cost found to be unnecessary in the efficient delivery of needed health services."

In 1966, the Secretary issued Medicare reasonable cost regulations to establish guidelines for cost reimbursement and codified regulations on the allowability of interest expense.²⁰ These regulations were initially codified in Subpart D of 20 C.F.R. Part 405, entitled "*Principles of Reimbursement for Provider Costs and for Services by Hospital-based Physicians*."²¹

As part of the initial 1966 regulations, the Secretary codified a regulation to address the allowability of interest expense at 20 C.F.R. § 405.419.²² Following redesignation,²³ this

¹⁶ Provider's Consolidated Optional Response (hereinafter "Provider's Response") at 3 and the related Ex. P-3 at 1-5 (Jun. 30, 2025). The Board notes that the Provider filed Ex. P-1 through P-9 with its FPP and different Ex. P-1 through P-3 with its Response. Citations will clearly identify which one is being addressed to avoid confusion.

¹⁷ Pub. L. 89-97, 79 Stat. 286 (1965).

¹⁸ *Id.* at § 102(a), 79 Stat. at 296.

¹⁹ *Id.* at § 102(a), 79 Stat. at 322-323.

²⁰ 31 Fed. Reg. 14808 (Nov. 22, 1966).

²¹ 20 C.F.R. § 405.419, later redesignated to 42 C.F.R. § 405.419, in 42 Fed. Reg. 52826 (Sept. 30, 1977), later redesignated to 42 C.F.R. § 413.153 in 51 Fed. Reg. 34793-794 (Sept. 30, 1986).

²² 31 Fed. Reg. at 14813.

²³ See *supra* note 21.

regulation (as amended) is currently located at 42 C.F.R. § 413.153. Medicare's core principles for interest expense allowability have essentially remained intact since Medicare reasonable cost regulations,²⁴ and, in general, state that "necessary and proper" interest expense is allowable when it is "incurred on indebtedness established with lenders or lending organizations not related through control, ownership, or personal relationship to the borrower."²⁵ Specifically, Medicare regulations at 42 C.F.R. § 413.153 (2017) state, in pertinent part:

(a)(1) *Principle*. Necessary and proper interest on both current and capital indebtedness is an allowable cost. . . .

(b) *Definitions*—(1) *Interest*. Interest is the cost incurred for the use of borrowed funds. Interest on current indebtedness is the cost incurred for funds borrowed for a relatively short term. This is usually for such purposes as working capital for normal operating expenses. Interest on capital indebtedness is the cost incurred for funds borrowed for capital purposes, such as acquisition of facilities and equipment, and capital improvements. Generally, loans for capital purposes are long-term loans.

(2) *Necessary*. Necessary interest is interest that meets the following requirements:

(i) It is incurred on a loan made to satisfy a financial need of the provider. Loans that result in excess funds or investments are not considered necessary.

(ii) It is incurred on a loan made for a purpose reasonably related to patient care.

(iii) It is reduced by investment income except income from—

(A) Gifts, grants, and endowments, whether held separately or pooled with other funds;

(B) Funded depreciation that meets the program's qualifying criteria;

(C) The provider's qualified pension funds;

(D) The provider's deferred compensation funds that meet the program's qualifying criteria; and

(E) The provider's self-insurance trust funds that meet the program's qualifying criteria.

²⁴ Compare 42 C.F.R. § 413.153 (2017) to 20 C.F.R. § 405.419 published in 31 Fed. Reg. at 14813.

²⁵ 42 C.F.R. § 413.153(c)(1).

(iv) It is not reduced by interest received as a result of judicial review by a Federal court (as described in § 413.64(j)).

(3) *Proper*. Proper requires that interest be—

(i) Incurred at a rate not in excess of what a prudent borrower would have had to pay in the money market existing at the time the loan was made; and

(ii) Paid to a lender not related through control or ownership, or personal relationship to the borrowing organization. However, interest is allowable if paid on loans from the provider's donor-restricted funds, the funded depreciation account, or the provider's qualified pension fund. . . .

(c) *Borrower-lender relationship*. (1) Except as described in paragraph (c)(2) of this section, to be allowable, interest expense must be incurred on indebtedness established with lenders or lending organizations not related through control, ownership, or personal relationship to the borrower. Presence of any of these factors could affect the ‘bargaining’ process that usually accompanies the making of a loan, and could thus be suggestive of an agreement on higher rates of interest or of unnecessary loans. Loans should be made under terms and conditions that a prudent borrower would make in arm’s length transactions with lending institutions. The intent of this provision is to assure that loans are legitimate and needed, and that the interest rate is reasonable. Thus, interest paid by the provider to partners, stockholders, or related organizations of the provider would not be allowable. . . .

Section 202 of the Provider Reimbursement Manual, CMS Pub. No. 15-1 (“PRM 15-1”), expands upon the principle stated at 42 C.F.R. § 413.153(a)(1). Section 202.1 states, in pertinent part:

Interest.—Interest is the cost incurred for the use of borrowed funds, generally paid at fixed intervals by the user. Interest on current indebtedness is the cost incurred for funds borrowed for a relatively short term, usually for 1 year or less. Current borrowing is usually for purposes such as working capital for normal operating expenses. Interest on capital indebtedness is the cost incurred for funds borrowed for capital purposes, such as the acquisition of facilities, equipment, and capital improvements. Generally, loans for capital purposes are long-term loans.

...

To be allowable under the Medicare program, interest must be:

- Supported by evidence of an agreement that funds were borrowed and that payment of interest and repayment of the funds are required;
- Identified in your accounting records;
- Related to the reporting period in which the costs are incurred; and
- Necessary and proper for the operation, maintenance, or acquisition of your facilities.

PRM 15-1 § 202.2 further details the criteria used to determine “necessary” interest expense as an allowable cost:

Necessary.—Only interest expense which is necessary is an allowable cost. To be considered necessary, the interest must be:

- Incurred on a loan that is made to satisfy a financial need,
- For a purpose related to patient care, and
- Incurred on a loan that is *reduced by investment income*.

...

Patient care funds should be available for the provider's patient care purposes, enabling it to avoid interest expense attributable to unnecessary borrowing. When a provider diverts patient care related funds to other uses, there is an impact on any subsequent borrowing. Funds may be diverted in many ways with the most common being by transferring, making loans, or investing. Generally, a transfer is the assignment or conveyance of property or assets from one person or entity to another. The transfer vests in the receiver the rights that the transferor had therein. Transfers are addressed in subsection A. A loan, which is also addressed in subsection A, is generally the furnishing of something for temporary use with the agreement, expressed or implied, to repay it with or without interest. Investments, addressed in subsection C, are generally expenditures to acquire property or other assets in order to produce revenue or profit or the placing of money or property in business ventures or real estate so that they may produce revenue or gain.

A. Financial Need.—. . . .

If a provider transfers funds generated from patient care activities (or any funds that cannot be documented as funds not generated from patient care activities) to an organization related to the provider, as defined in Chapter 10, the funds transferred are considered available to the provider. If such funds could have been used to eliminate a borrowing or to result in a lesser borrowing, a portion of the borrowing equivalent to the amount transferred is considered unnecessary. Interest on that portion of the loan is not allowable. If part of a loan is considered unnecessary, repayments of the funds borrowed are applied first to reducing the allowable portion of the loan.

If funds generated from patient care are used to repay an unallowable borrowing, it is considered an investment of patient care related funds. Any investment income generated from the investment is used to offset otherwise allowable interest expense.

Any funds that cannot be documented as funds not generated from patient care are considered as funds generated from patient care. Where there are commingled funds, it is presumed that the commingled funds include funds generated from patient care activities unless the provider records are sufficient to overcome this presumption. The burden of proof to show the sources and application of funds within a chain organization rests with the chain organization. . . .

B. Purpose Related to Patient Care.—Where funds are borrowed for purposes of investing in other than the provider's own patient care related activities, interest expense is not allowable. Such a loan is not considered necessary.

C. Offset By Investment Income.—***Patient care funds should be available for the provider's patient care purposes, enabling it to avoid interest expense attributable to unnecessary borrowing. If funds generated from patient care activities are invested in nonpatient care related activities, the provider's allowable interest expense is reduced (offset) by the provider's investment income in order to determine the amount of interest expense that is necessary and therefore allowable.*** The investment income is only offset against allowable interest expense. See §2806.1.G.

Investment income for offset is the aggregate net amount realized from all investments of patient care funds in nonpatient care

related activities and may include interest, dividends, operating profits and losses, and gains and losses on sale or disposition of investments. The methodology for determining the amount of the investment income is determined in part by whether the investment is in a related or unrelated organization. While investments in another organization may be accounted for under either the cost method or the equity method for financial accounting purposes, it is the relatedness of the organizations that determines the methodology for determining investment income offset for Medicare payment purposes. If the organizations are related, investment income offset is determined under subsection 2. If they are not related, then subsection 1 applies.

Excluded from the definition of investment income is the investment income from:

- Grants, gifts, and endowments, whether restricted or unrestricted,
- Funded depreciation (see §226.2),
- Qualified pension funds (see §228),
- Deferred compensation funds (see §2140.3.C.3),
- Interest earned as a result of judicial review by a Federal Court (as described in 42 CFR 413.64(j), and
- Nonallowable borrowing.

...

*Any investment income (subject to offset) in excess of allowable interest expense is not used to offset other expenses. **If the aggregate net amount realized from all investments of patient care related funds is a loss, the loss is not allowable. The net loss is not added to interest expense and it is not an allowable expense. Where operating losses occur, there should be assurance that they are bona fide and do not represent any form of subsidy to the provider, its employees, hospital based physicians, etc.** For example, the loss realized by a subsidiary corporation holding rental property available to physicians at below costs is not bona fide. It is not included in the calculation of investment income.*

Investment income resulting from investment of funds not generated from patient care activities is not subject to offset. In addition, if the funds invested in nonpatient care activities are borrowed, the interest expense is not allowable and the investment income is not subject to offset.²⁶

Further, PRM 15-1 §202.2(C) continues with a discussion of investments in related and unrelated organizations:

1. Investments In Unrelated Organizations.—Investment income arising from the investment of funds generated from a provider's own patient care activities in unrelated providers or nonpatient care activities, corporations (including the purchase of stock), partnerships, etc., consists of the aggregate net amount realized from dividends, interest, net rental income, interest earned in temporary investment of withholding taxes, as well as all gains and losses except gains or losses realized from the disposal of assets used for the production of income in the ordinary course of business. If the aggregate net amount realized is a loss, the loss is not allowable. Any profit is treated as investment income and must be offset against interest expense in the same cost reporting period.

When a provider purchases stock in an unrelated organization, the investment income consists of dividends paid on the stock as well as any gain or loss on the eventual sale of the stock. If the stock is in a related organization, see subsection 2.

...

2. Investments in Related Organizations or Directly Owned Assets.—If a provider diverts its funds generated from patient care to invest in nonpatient care activities directly owned by the provider or in a related organization as defined in §1000ff, the funds generated are considered as investment income for purposes of the investment income offset. ***Investment income arising from the investments in related organizations, activities, corporations, subsidiaries, etc., consists of the provider's share of the related entity's net annual profits or losses as determined under generally accepted accounting principles.*** Any gain or loss on the eventual sale of the related organization is adjusted for undistributed profits/losses which had previously been offset. Investment income arising from nonpatient care activities directly held by the provider

²⁶ (Bold and italics emphasis added, underline emphasis in original).

(included in the provider's books) is determined under Medicare cost finding principles.

If a provider purchases stock in a related corporation, investment income is calculated based on its share of the related corporation's net operating profit and losses rather than dividends. If the investment in the related corporation is sold, any gain or loss realized on the sale also constitutes investment income. The original investment in the stock must be reduced by any dividends received and adjusted to add any profits and subtract any losses realized each year as investment income before calculating the gain or loss on the sale of the stock. If the aggregate net amount realized on the investments is a loss, the loss cannot be claimed in reimbursement.²⁷

Finally, PRM 15-1 § 2100 addresses Costs Related to Patient Care and states that “[a]ll payments to providers of services must be based on the reasonable cost of services covered under title XVIII of the Act and related to the care of beneficiaries[.]” Certain pertinent terms are further defined, as follows:

2102.1 Reasonable Costs.—Reasonable costs of any services are determined in accordance with regulations establishing the method or methods to be used, and the items to be included. Reasonable cost takes into account both direct and indirect costs of providers of services, including normal standby costs. The objective is that under the methods of determining costs, the costs for individuals covered by the program are not borne by others not so covered and the costs for individuals not so covered are not borne by the program.

Costs may vary from one institution to another because of scope of services, level of care, geographical location, and utilization. It is the intent of the program that providers are reimbursed the actual costs of providing high quality care, regardless of how widely they may vary from provider to provider, except where a particular institution's costs are found to be substantially out of line with other institutions in the same area which are similar in size, scope of services, utilization, and other relevant factors. Utilization, for this purpose, refers not to the provider's occupancy rate but rather to the manner in which the institution is used as determined by the characteristics of the patients treated (i.e., its patient mix - age of patients, type of illness, etc.).

Implicit in the intention that actual costs be paid to the extent they are reasonable is the expectation that the provider seeks to minimize its costs and that its actual costs do not exceed what a prudent and cost-conscious buyer pays for a given item or service. (See §2103.) If costs are determined to exceed the level that such buyers incur, ***in the absence of clear evidence that the higher***

²⁷ (Bold and italics emphasis added).

costs were unavoidable, the excess costs are not reimbursable under the program.

In the event that a provider undergoes bankruptcy proceedings, the program makes payment to the provider based on the reasonable or actual cost of services rendered to Medicare beneficiaries and not on the basis of costs adjusted by bankruptcy arrangements.

2102.2 Costs Related to Patient Care.—***These include all necessary and proper costs which are appropriate and helpful in developing and maintaining the operation of patient care facilities and activities.*** Necessary and proper costs related to patient care are usually costs which are common and accepted occurrences in the field of the provider's activity. They include personnel costs, administrative costs, costs of employee pension plans, normal standby costs, and others. Allowability of costs is subject to the regulations prescribing the treatment of specific items under the Medicare program.²⁸

DISCUSSION, FINDINGS OF FACT, AND CONCLUSIONS OF LAW:

Positions of the Parties

As previously stated, during West Park's cost report audit for FY 2017, the Medicare Contractor made adjustments to West Park's reported allowable interest costs.²⁹ West Park contends that the Cathcart Practices "were established to provide medical services to the local, rural community [and] that the [Cathcart] Practices were essential to provide access to healthcare services" in a designated Health Professional Shortage Area ("HPSA") for primary care services.³⁰ West Park contends the Cathcart Practices "are operated efficiently but that they are unprofitable due to unfavorable third-party payer reimbursement, highly episodic service demands arising from demand surges during tourist season, and the costs of recruiting and retaining physicians to work in the isolated, rural community."³¹

The Medicare Contractor determined that operating earnings from the ASC, a separate corporate entity **and** joint venture in which West Park has an ownership interest, constituted investment income.³² However, the Medicare Contractor deemed the investment losses for Cathcart Practices to not be "bona fide," due to physician subsidization, and therefore, did not net the investment losses of the Cathcart Practices against the investment income from the ASC.³³

West Park argues that the Medicare Contractor's calculated net investment income amounts for the fiscal years under appeal are improper:

²⁸ (Emphasis added).

²⁹ Ex. C-7.

³⁰ Provider's Response at 2; *see also* Ex. P-4 (which provides that Cody, Wyoming is a Health Professional Shortage Area for primary care services, designated by the federal Health Resources & Services Administration ("HRSA")).

³¹ Provider's Optional Response at 2.

³² Medicare Contractor's FPP at 10; *see also* Provider's FPP Ex. P-3 and Ex. C-15.

³³ Medicare Contractor's FPP at 11.

Under the MAC's (erroneous) calculation the investment income is calculated by taking the sum of investment income gains, represented in Column B, and offsetting the investment gains against the Provider's interest expense claimed, as represented in Column A. Pursuant to the direction of the PRM, Column E reflects the correct sum of investment income that takes into account both investment income and losses, which should then be offset against the Provider's interest expense in Column A. Column G, therefore, reflects the correct allowable interest expense for the Provider.³⁴

The table below, which is derived from West Park's FPP, details the discrepancy between West Park's calculation and the Medicare Contractor's adjustments.

	A	B	C	D	E	F	G
FYE	Interest Expense Claimed [As Filed Cost Report] (Wksht. A, Line 113)	Medicare Contractor's Adjustment for Investment Income (Wksht. A-8)	Medicare Contractor's Calculated Allowable Interest Expense	Investment Losses From Cathcart's Practices	Corrected Investment Income	Greater of Investment Income or Zero	Allowable Interest Expense
2017	\$ 2,448,679	\$1,050,270	\$1,398,409	\$4,514,351	\$ (3,464,081)	\$ -	\$2,448,679
2018	\$ 2,401,100	\$1,279,940	\$1,121,160	\$2,831,003	\$ (1,551,063)	\$ -	\$2,401,100
2019	\$ 2,325,495	\$ 614,239	\$1,711,256	\$2,534,804	\$ (1,920,565)	\$ -	\$2,325,495
2020	\$ 2,245,657	\$1,048,820	\$1,196,837	\$2,571,834	\$ (1,523,014)	\$ -	\$2,245,657
2021	\$ 1,730,868	\$1,330,845	\$ 400,023	\$1,897,118	\$ (566,273)	\$ -	\$1,730,868

The Medicare Contractor contends that, in the above table, Column G does not reflect the Provider's "net" allowable interest expense which would be reported on the Medicare Cost Report Worksheet A, Line 113, Column 7.³⁵ Further, the Medicare Contractor notes Column C in the above table does not reflect the correct or proper calculation of West Park's allowable interest expense, giving an example of how 2017 should be calculated differently.³⁶

The Medicare Contractor notes the parties do not object to the inclusion of investment income from the ASC but disagree as to the treatment of "losses from the MOB and other investment operations when determining the net investment income for the purpose of offsetting interest expense."³⁷

³⁴ Provider's FPP at 4. The Board notes that column C for 2017 was incorrectly calculated in the Provider's FPP and has been corrected here.

³⁵ Medicare Contractor's FPP at 9.

³⁶ *Id.* at 9-10.

³⁷ *Id.* at 10-11.

West Park argues that the Medicare Contractor erred in its calculation by failing to account for losses of Cathcart Practices (*i.e.*, the losses of the practices in the MOB) and then offsetting the investment income by those losses.³⁸ In particular, West Park contends:

The Board should reject the MAC's scattershot arguments against inclusion of Cathcart's losses as contrary to the plain language of the PRM 15-1 at § 202.2. The MAC's Preliminary Position Paper (PPP) argues that the Cathcart losses are not bona fide but offers *no basis* for this determination. *See* MAC's PPP at 5-6 (offering no explanation for position for why losses would not be bona fide). Next, the MAC tries to reverse the PRM's presumption that funds are considered generated from patient care unless proven otherwise by wrongly placing the burden on the Provider to demonstrate that the Cathcart investment used funds from patient care activities. Finally, the MAC alleges, without basis or evidence, that the Provider used an incorrect accounting method that precludes inclusion of the Cathcart losses into the netting of investment income. This argument also contradicts the PRM's direction that it is not the accounting method, but "the relatedness of the organizations that determines the methodology for determining investment income offset for Medicare payment purposes." PRM § 202.2(C)(2). The Board should reject all the MAC's arguments as contrary to the PRM's directions.³⁹

In response to West Park's argument, the Medicare Contractor notes that, during the FY 2017 audit, the auditor's workpaper stated that the losses are *not* "bona fide" since West Park subsidizes its physicians, and cited to PRM 15-1 § 202.2(C).⁴⁰ Specifically, the audit workpaper, states:

[T]he provider states that they own the Physician Groups that occupy space in the MOB. *The Physician Groups all lose money and the hospital has to subsidize those entities*, creating a loss that the provider is arguing should be netted against investment gains earned elsewhere.⁴¹

West Park contends that it has established its Cathcart Practices as "bona fide" and that the "relatedness" between itself and its practices should apply and determine the appropriate investment income offset:

As the Provider has described, the Cathcart Practices with operating losses at issue consist of such essential practices as obstetrics & gynecology ("OBGYN"), internal medicine,

³⁸ Provider's FPP at 8.

³⁹ *Id.* at 8-9.

⁴⁰ Medicare Contractor's FPP at 11-12.

⁴¹ Ex. C-8 at C0101 (emphasis added).

cardiology, urgent care, psychiatric care, and ENT/audiology. Due to multiple factors outside of the Provider's control, including unfavorable third-party payer reimbursement, highly episodic service demands arising from demand surges during tourist season, and the costs of recruiting and retaining physicians to work in the isolated, rural community, the Practices are operated by the Provider at a loss. That the Provider had to provide these necessary services at a loss does not make them un- "bonified." [sic]⁴²

Board Analysis

The Board's analysis begins with the regulatory provisions and sub-regulatory guidance regarding the allowability of interest expense, as addressed above. Specifically, Medicare regulations at 42 C.F.R. § 413.153 state, in pertinent part:

(a)(1) *Principle*. Necessary and proper interest on both current and capital indebtedness is an allowable cost.

Furthermore, PRM 15-1 § 202.2, as quoted *supra*, discusses costs which are deemed *necessary* and indicates a financial need is required in order for interest expense to be allowable, and PRM 15-1 § 202.2(C) discusses scenarios related to offsetting interest expense by investment income.

The Board first looks to the Medicare Contractor's audit workpaper for FY 2017 dated May 8, 2019.⁴³ In this audit workpaper, which was made as part of the Medicare Contractor's review of West Park's FY 2017 cost report, the Medicare Contractor documents the disagreement between the parties regarding the proposed investment income offset. This audit workpaper summarizes points that the parties made in their various communications on the issue. In particular, this workpaper states:

[T]he provider presented an argument that the investment income offset should be reduced for the losses they incur with owning/operating a MOB, plus the losses relating to each organization (which the provider owns) that occupies that building. For example, the provider states that they own the Physician Groups that occupy space in the MOB. The Physician Groups all lose money ***and the hospital has to subsidize those entities***, creating a loss that the provider is arguing should be netted against investment gains earned elsewhere. The provider did present this argument in their position [sic] and we reviewed the theory for reasonableness. In our opinion, the providers argument is in violation of the PRM 15-1, Section 202.2C which, in part, discusses the differences between bona fide vs. non-bona fide losses. Based on what was discussed on the call and what is being presented in the position paper (including the PRRB case that was

⁴² Provider's FPP at 10.

⁴³ A copy is available both in Provider's FPP Ex. P-1 and in Ex. C-8.

cited in the provider's response, the provider's losses in the MOB would be non-bona fide and not allowable as a reduction to the net investment income offset. The PRM gives a very good example that mirrors our discussion. It is important to mention as well that all of the activities of the MOB are reported on the cost report in mostly non-reimbursable [sic] cost centers[.]⁴⁴

Subsequently, the Medicare Contractor issued a letter to West Park, dated July 24, 2019,⁴⁵ after the Medicare Contractor had issued West Park's FY 2017 NPR on July 11, 2019.⁴⁶ This letter documents, at length, the subsequent discussions between the parties, in which the "parties agreed that the [ASC] investment income of \$1,066,038 is required to be offset against allowable interest expense[.]"⁴⁷ The remaining point of contention, and the issue presented to the Board, relates to whether the Cathcart Practice losses should be offset against the ASC investment income, thus reducing the interest income to be offset against interest expense. The Board looks to the final pages of this letter where the Medicare Contractor requested additional information:

In order to verify the determination if PRM-1, 202.2(C)(1) or PRM-1[,] 202.2(C)(2) apply, could you please provide answers to the following questions ***and provide any supporting documentation requested*** to assist in the final decision-making process.

Additional Requested Information

- 1) The Hospital license and licensing survey to show whether the SNF, HHA, Hospice, and MOB physician practice entities are or are not licensed under the Hospital license.
- 2) ***Contracts with Physicians Operating the Physician Practices and the other MOB Offices*** that WPHD is requesting to have the operating losses related to these entities netted against the ASC joint venture investment income.
- 3) ***Lease Agreement for Space Rental*** (If applicable)
- 4) A sample of Medicare Billing forms (UB-04s or CMS-1500s) for 3 ASC claims and 3 Physician Private Practice claims (Preferably 1 from 3 different practices)
- 5) Related Organization (MOB)
 - a) Where were the sources of the funds used to purchase/build the MOB arrived from? Were patient care funds used to purchase/build the MOB?
 - b) Was borrowing used to finance the MOB building?
 - c) Were patient care funds used to purchase/build the MOB?⁴⁸

⁴⁴ Provider's FPP Ex. P-1 at 1 (bold and italics emphasis added). *See also* Ex. C-8 at C0101 (duplicate copy of the workpaper).

⁴⁵ A copy of the July 24, 2019 letter is located both in Provider's FPP Ex. P-3 and in Ex. C-15.

⁴⁶ *See* Ex. C-1.

⁴⁷ Provider's FPP Ex. P-3 at 1.

⁴⁸ *Id.* at 23.

It appears that West Park never furnished the Medicare Contractor with the documents requested in the July 24, 2019 letter (whether in response to that letter or subsequently in connection with other fiscal years' audits). Regardless, West Park did not include any of these documents in the record for the instant cases. As explained in more detail below, these documents would have been useful had they been included in the record for the instant cases because they could have assisted the Board in fully understanding the relationship/investment structure between West Park and its entities (including both the practices and MOB) and assessing whether the loss calculations made by West Park were bona fide losses, in view of its subsidization of the MOB and/or physicians practicing in the MOB.

The Board reviewed the record in full for the instant cases and nowhere in the record did West Park substantiate that relationship between West Park and the Cathcart Practices (including the MOB and physicians practicing therein). Instead, West Park relied on unsupported contentions in its preliminary, final and responsive position papers without producing valid evidence outside of arguments related to the Medicare Contractor's position. Nowhere in the record did the Provider produce documentation supporting the nature of the relationship between West Park and the Cathcart Practices, including but not limited to the Medicare Contractor's requested contractual agreements, space and lease agreements, and the source and uses of funding used to substantiate the building of the MOB.

Furthermore, while reviewing the exhibits, the Board could not reconcile the summary figures presented in the Medicare Contractor workpapers to the summary figures provided in West Park's exhibits, even though West Park originally prepared both sets. For example, the Board reviewed the one-page Exhibit P-5 that is attached to West Park's Final Position Paper and is described in the Exhibit List thereto as "Practice Income Statements 2017." However, when the Board attempted to reconcile the direct operating costs reported in West Park's calculation of its operating losses⁴⁹ to the FY 2017 direct operating costs in West Park's "General Service Cost Allocations" Table,⁵⁰ it was unable to do so and discovered the following discrepancies in the summary figures presented in those documents:

<i>DIRECT OPERATING COSTS</i>			
Operating Unit	Ex. P-5	Ex. C-8	Variance
Urgent Care Clinic (WS A Line 194.07)	1,008,221	912,682	95,539
Psychiatric Clinic (WS A Line 194.11)	772,870	686,470	86,400
Internal Medicine (WS A Line 194.16)	2,315,045	2,153,039	162,006
ENT & Audiology (WS A Line 194.18)	1,633,252	1,551,282	81,970
OB/GYN (N/A)	1,616,708	-	1,616,708

⁴⁹ Provider's FPP Ex. P-5 at 1.

⁵⁰ Ex. C-8 at C0127.

On the same schedules, after the inclusion of allocated general services costs, the Board notes the following variances remain, as shown below:

<i>CALCULATED TOTAL COSTS INCLUDING ALLOCATED GENERAL SERVICE COSTS</i>			
Operating Unit	Ex. P-5	Ex. C-8	Variance
Urgent Care Clinic (WS A Line 194.07)	1,381,809	1,376,115	5,694
Psychiatric Clinic (WS A Line 194.11)	912,600	900,708	11,892
Internal Medicine (WS A Line 194.16)	2,912,704	2,771,539	141,165
ENT & Audiology (WS A Line 194.18)	2,156,032	2,176,425	(20,393)
OB/GYN (N/A)	2,257,223	-	2,257,223

These variances in total costs are not simply the variance between the direct costs noted in the table above, thus confirming that the general service cost allocations on Exhibits P-5 and C-8 vary, as well.

Finally, in attempting to recalculate the losses for FY 2017 for the Cathcart Practices, the Board found that it could not validate those losses with the minimal summary workpapers provided, and notes that no back up documentation such as detailed practice revenue figures were supplied to the Board to permit a proper recalculation or verification of the alleged losses. Indeed, the Board notes that it thoroughly reviewed the submitted exhibits and that it was the Medicare Contractor, not West Park, that supplied compelling underlying data for the Board to render a decision. The Board contends it should have received the underlying documentation to support West Park's claims from West Park itself as it is West Park that has the burdens of proof and production of evidence.⁵¹ The variance between the figures West Park provided to the Medicare Contractor during the audit when compared to the figures West Park provided to the Board as evidence for the hearing brings into question the accuracy of West Park's financial records.

The Board also reviewed the abstracts from West Park's audited financial statements included at Exhibit C-7.⁵² Note 5 to those financial statements identifies the total FY 2017 Investment Income as Interest and Dividends of \$1,066,496 and Increase (not loss) in Fair Value of Investments of \$964,680.⁵³ As discussed, *supra*, \$1,066,038 was identified as investment income on the ASC, and the parties agreed that it should be offset.⁵⁴ Further, the Board notes no mention of the Cathcart Practices in the portion of the financial statements included in Exhibit C-7. Mention is made of investments in joint ventures for the Northern Wyoming Surgical Center, LLC, the Cody Medical Arts Complex, LLC, and the Big Horn Basin Regional Dialysis Center,

⁵¹ 42 C.F.R. § 405.1871(a)(3).

⁵² Ex. C-7 at C0095-97.

⁵³ *Id.* at C0095.

⁵⁴ See Provider's FPP Ex. P-3 at 1.

LLC.⁵⁵ Additionally, the summary of other revenues, originally prepared by West Park and identified as Support for Worksheet A-8 Adjustments, included in Exhibit C-9,⁵⁶ includes the \$1,066,038 investment income, identified as “JV dividends,” but does not address any gains or losses on the Cathcart Practices. West Park has failed to document its calculations of the claimed loss amounts with any verifiable support, and based on the record established for the instant cases, the Board is unable to verify the claimed loss amounts through the portion of the audited financial statements provided.

West Park’s responsibility for maintaining proper supporting documentation is set forth in 42 C.F.R. § 413.20, which states:

Financial data and reports. (a) *General.* The principles of cost reimbursement **require that providers maintain sufficient financial records and statistical data for proper determination of costs** payable under the program.⁵⁷

Such supporting documentation generally should be contemporaneous to the relevant period.⁵⁸ Furthermore, 42 C.F.R. § 413.24(c) elaborates on the requirements for data accuracy:

Adequate cost information must be obtained from the provider's records to support payments made for services furnished to beneficiaries. ***The requirement of adequacy of data implies that the data be accurate and in sufficient detail*** to accomplish the purposes for which it is intended.⁵⁹

As noted in the Commentary to Board Rule 23.3 (2021), “the Board requires preliminary position papers to be **fully** developed and include **all** available documentation necessary to provide a thorough understanding of the parties’ positions.”⁶⁰ To this end, under Board Rule 25.2, West Park’s preliminary position paper filing was required to include “**all** available documentation as exhibits to fully support your position.”⁶¹ Indeed, a prerequisite for Board approval of a case for record hearing is that “the record must be substantially complete.”⁶²

⁵⁵ Ex. C-7 at C0095-96.

⁵⁶ *Id.* at C0093; Ex. C-9 at C0132.

⁵⁷ (Bold and underline emphasis added).

⁵⁸ See *Community Hosp. of Monterey Peninsula v. Thompson*, 323 F.3d 782, 799 (9th Cir. 2004) (upholding the Secretary’s interpretation of 42 C.F.R. § 413.20(a) to require providers to maintain contemporaneous documentation); *Mercy Gen. Hosp. v. Azar*, 410 F.Supp.3d 63, 83 (D.D.C. 2019) (affirming the Secretary’s interpretation of 42 C.F.R. § 413.20 to require “contemporaneous” documentation).

⁵⁹ (Bold, italics and underline emphasis added).

⁶⁰ (Emphasis in original.)

⁶¹ Board Rule 25.2.1 (2021) (emphasis in original). Board Rule 25.2.2 addresses “Unavailable or Omitted Documents” and specifies: “If documents necessary to support your position are still unavailable, then provide the following information in the position papers: 1. Identify the missing documents; 2. Explain why the documents remain unavailable; 3. State the efforts made to obtain the documents; and 4. Explain when the documents will be available. Once the documents become available, promptly forward them to the Board and the opposing party.”

⁶² Board Rule 32.4 (2021). Notwithstanding, West Park still could have **potentially** submitted additional documentation up to October 17, 2025 when the record closed in this case, pursuant to the September 17, 2025 Notice of Record Hearing. Any such submission, though, would have been subject to Board Rule 35.3 which

In accordance with 42 C.F.R. § 405.1871(a)(3):

[A Board hearing] decision must include findings of fact and conclusions of law regarding the Board's jurisdiction over each specific matter at issue (see § 405.1840(c)(1)), and *whether 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.*⁶³

Furthermore, “[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.”⁶⁴ In *Consolidated Edison Co. v. NLRB*, 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.”⁶⁵ 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 interpretive rules, general statements of policy, and rules of agency organization, procedure, or practice established by CMS.”⁶⁶

Based on the Board’s review, West Park has not satisfied its burdens of proof and production of evidence. Based on the lack of information and evidence in the record on the nature of the arrangement between West Park and the Cathcart Practices (including the MOB and the physicians practicing therein), the Board is unable to determine whether their losses should in fact be offset/netted against the ASC investment income in computing West Park’s allowable interest expense. Regardless, even if the Board had received satisfactory documentation of the West Park-Cathcart Practices arrangement to support a finding that the losses from the Cathcart Practices *could* be included, it would not change the Board’s ruling because the summary data West Park has presented to support the calculation of the claimed losses would not be sufficient

specifies, in pertinent part: “Except on agreement of the parties, documentary evidence relevant to fact disputes must be identified and exchanged by the deadline established in the PJSO or by these rules. . . . The parties are encouraged to discuss whether there will be objections to exhibits prior to the hearing and attempt to work out differences. If the parties agree, exhibits may be added up to the time of the hearing. Generally, additional legal authorities or summaries will not be subject to these time limits. At the commencement of the hearing, the Board will ask the parties to identify their respective exhibits and will ask if there are any objections to the opposing party’s exhibits. Upon objection or the Board’s own motion, the Board will determine the propriety of permitting late filed exhibits, taking into account the reasons for the late filing and the requirements of Rules 23 through 27, and prejudice to the opposing party.”

⁶³ (Bold and italics emphasis added).

⁶⁴ 42 U.S.C. § 1395oo(d). This statutory provision also confirms: “[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).

⁶⁵ 305 U.S. 197, 229 (1938). See also *Pomona Valley Hosp. Med. Ctr. v. Becerra*, 82 F.4th 1252, 1258-59 (D.C. Cir. 2023).

⁶⁶ 42 C.F.R. § 405.1867.

to support the allowance of the claimed amount because the summary data cannot be verified in the record before the Board and West Park has not presented sufficient evidence to support the accuracy of the loss calculations.

Further, the Board addresses West Park's argument that the Medicare Contractor failed to properly support its finding that the losses were not "bona fide":

Even in its Final Position Paper, the MAC still offers no specific rationale why the Practice losses are not bona fide, aside from their mere existence. Essentially the MAC's reasoning is that covering a loss constitutes a subsidy and, since subsidies are not considered bona fide losses, the losses are not bona fide either. As explained further below, it cannot be the case that no losses can be bona fide since the PRM explicitly contemplates the inclusion of losses as offsets against gains.⁶⁷

The Medicare Contractor noted, in its FY 2017 audit workpaper that "the [p]hysician [g]roups all lose money and the hospital has to subsidize those entities, creating a loss that the [P]rovider is arguing should be netted against investment gains earned elsewhere."⁶⁸ Here, the Board refers back to the PRM-I § 202.2(C) guidance regarding the inclusion of operating losses:

Where operating losses occur, *there should be assurance that they are **bona fide** and do not represent any form of subsidy to the provider, its employees, **hospital based physicians**, etc.*⁶⁹

The Board notes that PRM 15-1 § 104.24 also provides a definition of "bona fide sale," which states:

A bona fide sale contemplates ***an arm's length transaction*** between a willing and well informed buyer and seller, neither being under coercion, for reasonable consideration. An arm's-length transaction is a transaction negotiated by unrelated parties, each acting in its own self interest.⁷⁰

Additionally, the regulation at 42 C.F.R. § 413.134, addressing depreciation, frequently describes "bona fide" in the terms of relative gains and losses on the disposal of assets, and provides context to the term "bona fide" when defining the term "fair market value":

Fair market value is the price that the asset would bring by ***bona fide bargaining between well-informed buyers and sellers*** at the date of acquisition. ***Usually the fair market price is the price that***

⁶⁷ Provider's Response at 5.

⁶⁸ Medicare Contractor's FPP at 11-12 and Ex. C-8 at C0101. (The Board notes that the audit workpaper was signed and dated by the auditor on 5/8/2019, prior to the filing of the instant appeal.)

⁶⁹ (Emphasis added).

⁷⁰ PRM 15-1 § 104.24, added via Transmittal 415 (May 2000) (bold and italics emphasis added).

bona fide sales have been consummated for assets of like type, quality, and quantity in a particular market at the time of acquisition.⁷¹

In previous Board cases, the Board has cited to the following definition of “bona fide” given in the Black’s Law Dictionary (sixth edition):

A completed transaction in which seller makes sale in good faith, for valuable consideration without notice of any reason against the sale.⁷²

In one specific case, *University of CA Irvine Med. Ctr. v. Blue Cross and Blue Shield Ass’n et al.*,⁷³ ownership of a county-owned hospital was transferred to a state university and the Board found that the sale was not “bona fide” because the price paid (\$5.5 million) was below the market value of the assets sold (\$19.1 million). Moreover, the sales agreement to the university included a restriction that that the university supply medical care to indigent residents under specified conditions.⁷⁴

As stated above, a “bona fide” sale contemplates an arm’s length transaction between unrelated parties for reasonable consideration, with each party acting in its own self-interest. With the information and evidence provided in the record by West Park, the Board is unable to determine the nature of the relationship and, in particular, unable to validate whether or not West Park’s arrangement with Cathcart Practices involved an improper subsidy.

The Board again looks to PRM 15-1 § 202.2(C), specifically the example provided:

For example, *the loss realized by a subsidiary corporation **holding rental property available to physicians at below costs** is **not bona fide**. It is not included in the calculation of investment income.*⁷⁵

The Board finds this example is very similar to the alleged relationship between West Park and Cathcart Practices. The contractual agreements between the Provider and the various physician practices are not in the record, and the Board is unable to determine the terms of the physicians’ rental of (or right to use) the MOB space or other aspects of the relationship between West Park and Cathcart Practices.⁷⁶ As a result, without contractual agreements with Cathcart Practices

⁷¹ 42 C.F.R. § 413.134(b)(2) (bold and italics emphasis added).

⁷² *Ashland Reg’l Med. Ctr. v. Blue Cross and Blue Shield Ass’n*, PRRB Dec. 1998-D032 at 6 (Feb. 27, 1998) (emphasis removed).

⁷³ PRRB Dec. 1985-D8 (Oct. 15, 1984).

⁷⁴ *Id.*

⁷⁵ (Emphasis added.)

⁷⁶ While the parties have stipulated that West Park owns the Cathcart Practices, it does not include any information on how that ownership was structured (e.g., as a professional limited liability corporation), whether there are separate ownership entities for each of the five practices and/or the MOB, and whether West Park’s ownership of each such entity is exclusive (i.e., **wholly** owned by West Park). As noted in the Board’s decision in *Anaheim* (see *infra* n. 78 and accompanying text), whether the Cathcart Practices is a separate legal entity(ies) may be a pivotal factor.

and/or the physicians thereof, or an understanding of the contractual arrangements with the MOB, as described earlier, the Board has no way of proving the losses were in fact “bona fide.” Thus, the Board finds that West Park’s alleged operating losses should **not** be offset/netted against investment income because the Provider failed to show that these losses were, in fact, “bona fide” by a preponderance of the evidence.

Finally, the Board looks back to a previous Board decision ruling on an offset to investment income, *Anaheim Mem’l Hosp. Ass’n v. Blue Cross and Blue Shield Ass’n* (“*Anaheim*”),⁷⁷ which both parties discuss in their final position papers.⁷⁸ In *Anaheim*, it is noted that, in 1987, the Anaheim Memorial Magnetic Resonance Imaging Center (“AMMRIC”) limited partnership was formed to create a free-standing facility on the hospital’s parking lot via a leasing arrangement to provide MRI services, with the hospital being a general partner with 72% interest.⁷⁹ The Board ultimately found the Medicare contractor’s adjustment to offset net investment income from the related organization to be proper, stating:

The Board finds a pivotal determining factor in this case was the fact AMMRIC was a separate legal entity, with an independent Medicare: i) agreement, ii) Provider number, iii) medical records, and iv) billing for all services performed. The Board notes the entire financial spectrum of rendering MRI services were recorded in the financial records and ultimately reflected on the financial statements of AMMRIC; such as costs, billed charges and receipts of payments, etc.

....

[T]he Board agrees the parties were related; and notes the [hospital’s] financial statement reported its investment in AMMRIC under the equity method of accounting as permitted under generally accepted accounting principles which underscores the reality that this was an investment.⁸⁰

In contrast to the *Anaheim* decision, the Board notes that the Cathcart Practices may, in fact, be operating units of the hospital as evidenced by the fact that they are recorded on West Park’s Medicare cost report as line items on Worksheet A.⁸¹ While West Park contends, based on its reading of the *Anaheim* decision, that there was a basic intention to have a business relationship and to produce profits which equates as an investment, the Board notes West Park **never** supplied documentation indicating the Cathcart Practices were separately licensed by Medicare and

⁷⁷ PRRB Dec. 1999-D42 (Apr. 29, 1999) (“*Anaheim*”) (copy at Ex. C-8 at C0111).

⁷⁸ See Provider’s FPP at 7-8; Medicare Contractor’s FPP at 13-14.

⁷⁹ *Anaheim* at 11.

⁸⁰ *Id.* at 13.

⁸¹ However, conflicting evidence is located in Ex. C-8 at C0108-09 (a May 1, 2019 letter from the CFO of Cody Regional Health/West Park to Noridian) in which the CFO asserts they should not be considered an operating unit because the MOB/physician practices are not “performing health services on or with or to [West Park] patients.” This conflict highlights the Board’s frustration with this case and highlights West Park’s failure to meet its burdens of proof and production of evidence.

maintained separate financial records, which was the core conclusion by the Board in *Anaheim*.⁸² The Board agrees with the Medicare Contractor's assessment that the Cathcart Practices are therefore not investments, and as a result, the profits and losses related to these services should not be offset against the investment income of the ASC.

Accordingly, for the reasons set forth above, the Board finds that the Medicare Contractor was proper in determining West Park's allowable interest expense for FY 2017 through FY 2021.

DECISION AND ORDER:

After considering Medicare law, regulations, and program guidance, the arguments presented, and the evidence admitted, the Board finds that the Medicare Contractor properly calculated West Park's allowable interest costs for FYs 2017, 2018, 2019, 2020, and 2021.

BOARD MEMBERS:

Kevin D. Smith, CPA
Ratina Kelly, CPA
Nicole E. Musgrave, Esq.
Shakeba DuBose, Esq.
Clayton J. Nix, Esq.

FOR THE BOARD:

9/29/2026

X Kevin D. Smith, CPA

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

⁸² See, e.g., the following unsupported statement in the Provider's FPP at 1: "The [Cathcart Practices] are directly owned by the Provider but furnish and bill for physician office services under their own National Provider Identification ("NPI"), Medicare provider numbers, and other provider numbers separate from the Provider that are assigned to each Practice."