

PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

On the Record
2026-D32

PROVIDER –
Memorial Hermann – Memorial City Hospital

PROVIDER NUMBER –
45-0610

vs.

MEDICARE CONTRACTOR –
Novitas Solutions, Inc.

RECORD HEARING DATE –
December 4, 2023

FISCAL YEARS ENDED –
June 30, 1996, June 30, 1998, June 30,
2000, June 30, 2001

CASE NUMBERS –
01-2533, 01-2535, 03-1411, 04-2243

INDEX

	Page No.
Issue Statement	2
Decision of Board Majority	2
Introduction and Procedural History	2
Statement of Relevant Law	5
Statement of Relative Facts.....	15
Discussion, Findings of Fact, and Conclusions of Law	17
Decision of Board Majority and Order	28
Board Member DuBose, Concurring in Part, Dissenting in Part	29

ISSUE STATEMENT:

Does the Board have jurisdiction over the issue of whether the Provider is entitled to reimbursement for the implicit interest component of costs of ownership in the capital lease or virtual purchase of certain hospital assets?¹

DECISION OF BOARD MAJORITY:

The Board concludes that Provider does not have a right to appeal the capital lease interest cost at issue under 42 U.S.C. §1395oo(a) for fiscal years (“FYs”) 1996, 1998, 2000 and 2001 and declines to hear the matter pursuant to its discretionary powers under 42 U.S.C. §1395oo(a).

INTRODUCTION AND PROCEDURAL HISTORY:

Memorial Hermann - Memorial City Hospital (“Memorial City” or “Provider”) is an acute care hospital located in Houston, Texas.² The Medicare contractor assigned to Memorial City is Novitas Solutions, Inc. (“Medicare Contractor”).³ This appeal consists of four (4) consolidated cases: Case Nos. 01-2533 (FYE 6/30/1996), 01-2535 (FYE 6/30/1997), 03-1411 (FYE 6/30/2000), and 04-2243 (FYE 6/30/2001).

In each of the aforementioned cases, the Provider timely filed appeals of the Medicare Contractor’s respective final determinations on multiple grounds.⁴ Subsequent to the filing of its appeal for FYE 2001, the Provider amended each of the remaining appeals to include a cost of ownership issue seeking reimbursement for implicit interest on its capital lease of certain

¹ See Provider’s Consolidated Final Position Paper (“Provider’s CFPP”) at 1 (Oct. 28, 2021); *see also* Medicare Contractor’s Consolidated Final Position Paper (“Medicare Contractor’s CFPP”) at 5 (Nov. 24, 2021); *but see* Parties’ Joint Stipulations (“2023 Stip.”) at ¶ 7 (Oct. 26, 2023) (“According to the MAC, the only issue the Board needs to decide in this Appeal is whether Provider must present additional proof to establish that incorrect advice that was provided by the MAC caused the omission of the implicit interest in the Lease payments on the Provider’s cost reports for the Cost Years at issue.”). The Board notes that Exhibits, and their numbering, differ between the October 28, 2021 Provider’s CFPP and the Dec. 20, 2021 Provider’s Consolidated Responsive Brief (“Provider’s CRB”), as such, exhibit references will include the related paper throughout this decision.

² Medicare Contractor’s CFPP at 2. The Board notes that the Provider is identified in the Board’s records as Memorial Hospital – Memorial City in Case Nos. 01-2533 and 01-2535 and Memorial Hermann – Memorial City Hospital in Case Nos. 03-1411 and 04-2243. Before January 1, 1994, the hospital then known as Memorial City Medical Center (“MCMC”), was owned and operated by a subsidiary of Metro National Corporation (“Metro”), a for-profit business corporation. Metro was principally a real estate development company. Negotiations began in 1993 between Metro and a separate, unrelated entity, Memorial Health System (“MHS”), to lease MCMC to MHS on a long-term basis. MHS was a not-for-profit corporation that in 1993 owned and operated three hospitals in Houston, Texas, where MCMC was also located. After the lease of MCMC to MHS, the leased hospital was known as Memorial Hospital – Memorial City. In 1997, MHS changed its name to Memorial Hermann Hospital System (“MHHS”). Thereafter, the leased hospital was known as Memorial Hermann Memorial City Hospital. *See also* 2023 Stip. at ¶¶ 1, 2.

³ CMS’ payment and audit functions under the Medicare program were historically contracted to organizations known as fiscal intermediaries (“FIs”), but 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 *See* Provider’s CFPP at 12 – 16; *see also* Provider’s CFPP Exhibit (“Ex.”) P-7 at 3 (Remand Order, *Memorial Hermann Memorial City Medical Center v. Burwell*, Case No. 4:17-CV-00065, *et al.* (S.D. Tex, Aug. 28, 2018)).

hospital assets.⁵ On June 21, 2004, the Medicare Contractor filed jurisdictional challenges in Case Nos. 01-2533, 01-2535, and 03-1411, challenging the Board's jurisdiction over the capital lease interest issue in each appeal because the costs challenged by Provider were unclaimed on the respective year cost reports.⁶

On September 12, 2014, the Provider Reimbursement Review Board ("Board") issued a jurisdictional decision in Case Nos. 01-2533 (FY 1996), 01-2535 (FY 1998), and 03-1411 (FY 2000), finding that it did not have jurisdiction to address the cost of ownership issue appealed by the Provider.⁷ The Board's decision stated the following:

42 U.S.C. § 1395oo(a) dictates that to obtain jurisdiction, a provider must be "dissatisfied" with a "final determination" of the intermediary. Thus, it follows that a provider must have claimed reimbursement for items and services for the intermediary to make a "final determination" regarding such items and services. The Provider in these cases failed to claim the imputed interest it now seeks. The Board generally has interpreted 42 U.S.C. § 1395oo(a) as the gateway to establishing Board jurisdiction to hear an appeal and requiring a provider to establish a right to appeal on a claim-by-claim or issue-specific basis.

Accordingly, the Board finds that only when the provider has established jurisdiction under § 1395oo(a) with respect to one or more of such claims/issues can the Board then exercise discretion to hear other claims not considered by the intermediary (*e.g.*, unclaimed costs). While the Provider did file a jurisdictionally valid appeal for dissatisfaction with issues other than the capital lease interest issue that gives the Board jurisdiction under subsection (a), the Board declines to exercise discretion under 42 U.S.C. § 1395oo(d) to hear the appeal of the capital lease interest issue as unclaimed costs when reimbursement of those costs was not precluded by a specific law, regulation, CMS Ruling or manual instruction.⁸

Likewise, on November 15, 2017, the Board issued a jurisdictional decision in Case No. 04-2243 (FY 2001), finding that it did not have jurisdiction to address the cost of ownership issue appealed by the Provider. The Board's decision stated, in pertinent part:

In this instant case, the Provider concedes it failed to properly claim the imputed interest associated with the lease on its as-filed cost [sic] report, which it now seeks to correct. Only in hindsight did the Provider determine that it could (and should) have reported

⁵ *Id.*

⁶ *See, e.g.* Jurisdictional Challenge in Case No. 01-2533 (June 21, 2004).

⁷ Provider's CFPP Ex. P-5 at 10.

⁸ *Id.* at 9-10.

this item differently, thereby potentially increasing the amount of reimbursement. However, uncertainty as to the interpretation of a regulation does not necessarily make a claim for reimbursement futile. Rather, this case is precisely the situation described by the Supreme Court in *Bethesda* as being “on different ground” because the Provider “fail[ed] to request from the intermediary reimbursement for all costs to which [it was] entitled under the applicable rules.

Using the rationale in the *St. Vincent* and *Bethesda* cases, the Board finds the errors and omissions for the Virtual Lease Interest Expense raised in the appeal were due solely to the Provider’s negligence in understanding the Medicare regulations governing the reimbursement of such items on the Medicare cost report. The Board also finds that only when a provider has established jurisdiction under § 1395oo(a) with respect to one or more of such claims/issues can the Board then exercise discretion to hear other claims not considered by the Medicare contractor (*e.g.*, unclaimed costs). While this Provider did file a jurisdictionally valid appeal for dissatisfaction with issues other than the Virtual Lease Interest Expense issue that gives the Board jurisdiction under subsection (a), the Board declines to exercise discretion under 42 U.S.C. § 1395oo(d) to hear the appeal of this issue as it addresses items and services not claimed, or not properly claimed.⁹

On January 10, 2017, Memorial City filed a complaint in the United States District Court for the Southern District of Texas challenging the Board’s September 12, 2014 jurisdictional decision. Subsequently, on January 19, 2018, Memorial City also filed a lawsuit in the U.S. District Court for the Southern District of Texas (“District Court”) seeking judicial review of the Board’s November 15, 2017 jurisdictional decision. On March 1, 2018, the District Court consolidated Case No. 04-2243 (FYE 2001) with Case Nos. 01-2533, 01-2535, and 03-1411 (FYEs 1996, 1998 and 2000 respectively).¹⁰ On August 28, 2018, the District Court set aside the Board’s September 12, 2014 and November 15, 2017 jurisdictional decisions and remanded the cases for further proceedings.¹¹

In setting aside the Board’s jurisdictional decisions, the District Court concluded that in the Board’s September 12, 2014 jurisdictional decision, “the Board assumed that Plaintiff’s failure to include imputed interest and property taxes on its cost report was due to inadvertence or mistake.”¹² The District Court also found, in the November 15, 2017 jurisdictional decision, that the Board, without addressing the Plaintiff’s claim that it received erroneous guidance from the Medicare Contractor, made an explicit finding that “the errors and omissions for the Virtual Lease Interest Expense were due solely to the Provider’s negligence in understanding the

⁹ Provider’s CFPP Ex. P-6 at 3-4.

¹⁰ Provider’s CFPP at 2-3 n. 2.

¹¹ Provider’s CFPP Ex. P-7 at 16.

¹² *Id.* at 6.

Medicare regulations governing the reimbursement of such items on the Medicare cost report.”¹³

The District Court acknowledged that it “must generally defer to the Board to resolve factual disputes” but is “required to set aside administrative decisions that are not supported by substantial evidence.”¹⁴ The District Court found, in its review of the two Board decisions, that the Board’s findings, both implicit and explicit, “without any analysis or explanation” which held that the Provider was “solely responsible for the omissions on its cost reports.”¹⁵ Accordingly, the District Court further held that the “factual finding in each administrative decision must therefore be set aside pursuant to the APA, *See* 5 U.S.C. § 706(e) (stating that courts must “hold unlawful and set aside agency action, findings, and conclusions found to be...unsupported by substantial evidence”).”¹⁶

As a result, the District Court reversed and remanded the Board’s decisions for Case Nos. 01-2533, 01-2535, 03-1411, and 04-2243, dated September 12, 2014 and November 15, 2017, for further proceedings consistent with its order.¹⁷ Consequently, by order dated December 19, 2018, the Centers for Medicare & Medicaid Services’ (“CMS”) Principal Deputy Administrator reversed and remanded to the Board.¹⁸ On April 15, 2021, the Board issued a Notice of Reopening pursuant to the previously issued Deputy Administrator’s Order of Remand. The Board approved a hearing on the record on December 4, 2023. Memorial City was represented by Selina Coleman, Esq. of Reed Smith LLP. The Medicare Contractor was represented by Bernard Talbert, Esq. of Federal Specialized Services.

STATEMENT OF RELEVANT LAW:

A. Capital-Related Costs

The Medicare program was established to provide health insurance to the aged and disabled. *See* 42 U.S.C. §§ 1395 *et seq.* CMS, formerly the Health Care Financing Administration (“HCFA”), is the operating component of the Department of Health and Human Services (“DHHS”) charged with administering the Medicare program.

The issue in this appeal concerns a virtual purchase lease (also referred to as a capital lease), which is addressed in 42 C.F.R. § 413.130. The Final Rule entitled *Revaluation of Assets* published on September 23, 1992 (“1992 Final Rule”) amended 42 C.F.R. § 413.130, entitled *Introduction to capital-related costs*, by adding new subsection (b)(8) effective October 23, 1992, and this new subsection stated, in its entirety:

(8) For lease purchase transactions entered into on or after October 23, 1992, a lease that meets any one of the following conditions establishes a virtual purchase:

¹³ *Id.* at 13.

¹⁴ *Id.*

¹⁵ *Id.* at 14.

¹⁶ *Id.*

¹⁷ *Id.* at 16.

¹⁸ CFPP Ex. P-8 (Administrator’s Dec. 20, 2018 Remand Order).

- (i) The lease transfers title of the facilities or equipment to the lessee during the lease term.
- (ii) The lease contains a bargain purchase option.
- (iii) The lease term is at least 75 percent of the useful life of the facilities or equipment. This provision is not applicable if the lease begins in the last 25 percent of the useful life of the facilities or equipment.
- (iv) The present value of the minimum lease payments (payments to be made during the lease term including bargain purchase option, guaranteed residual value, and penalties for failure to renew) equals at least 90 percent of the fair market value of the leased property. This provision is not applicable if the lease begins in the last 25 percent of the useful life of the facilities or equipment. Present value is computed using the lessee's incremental borrowing rate, unless the interest rate implicit in the lease is known and is less than the lessee's incremental borrowing rate, in which case the interest rate implicit in the lease is used.¹⁹

The 1992 Final Rule also added new subsection (b)(9), which stated, in pertinent part:

- (9)(i) If a lease establishes a virtual purchase under paragraph (b)(8) of this section, the rental charge is includable in capital-related costs to the extent that it does not exceed the amount that the provider would have included in capital-related costs if it had legal title to the asset (the cost of ownership). ***The cost of ownership includes straight-line depreciation, insurance, and interest.*** For purposes of computing the limitation on allowable rental cost in this paragraph, a provider may not include accelerated depreciation.²⁰

Simultaneously, the 1992 Final Rule also amended 42 C.F.R. § 413.134, entitled *Depreciation: Allowance for depreciation based on asset costs*, by adding a new paragraph (h), which included subsection (h)(5)(i), which stated:

- (5)(i) If a lease is a virtual purchase under paragraph (h)(4) of this section, the rental charge is includable in allowable costs only to the extent that it does not exceed the amount that the provider would have included in allowable costs if it had legal title to the asset (***the cost of ownership***), ***such as straight-line depreciation, insurance, and interest.*** For purposes of computing the limitation on allowable

¹⁹ 57 Fed. Reg. 43906, 43918 (Sept. 23, 1992).

²⁰ *Id.* (emphasis added).

rental cost in this paragraph, a provider may not include accelerated depreciation.²¹

As early as July 1967, guidance in the Provider Reimbursement Manual, CMS Pub. 15-1 (“PRM”), addressed *Sale and Leaseback and Lease-Purchase Agreements* in § 110. At that time, § 110(B) stated, in pertinent part:

Lease Purchase Agreements – Rental Charges – Some lease agreements are essentially the same as installment purchases of facilities or equipment. ***If the lease is a virtual purchase, the rental charge is includable in allowable costs only to the extent that it does not exceed the amount which the provider would have included in allowable costs had he had legal title to the asset, such as, for example, straight-line depreciation, insurance, and interest.***²²

The instructions in the PRM were last changed in February 1998, at which time, they stated the following and provided an example calculation:

(A)(2) When a hospital or SNF enters into a sale and leaseback arrangement on or after October 23, 1992...the amount that may be included as rental or lease expense may not exceed the amount that the provider would have included in its allowable costs had the provider retained legal title to the facility or equipment (i.e., the costs of ownership). ***The costs of ownership include items such as interest expense on mortgages, taxes, depreciation and insurance costs.***

* * *

(B)(2) If the lease is a virtual purchase, the rental charge is includable in allowable costs only to the extent that it does not exceed the amount which the provider would have included in allowable costs if it had legal title to the asset ***(the cost of ownership), such as straight-line depreciation insurance and interest.*** For purposes of computing the limitation on allowable rental cost, a provider may not include accelerated depreciation in its allowable costs.

* * *

EXAMPLE: A provider leased the following asset for 5 years at a cost of \$75,000 per year. The asset costs \$300,000 and has a useful life of 6 years. ***The cost of ownership was determined as follows:***

²¹ *Id.* at 43920 (emphasis added).

²² CMS Pub. 15-1, § 110(B) (1967) (Bold, italics, and underline emphasis added).

Cost	\$300,000
Useful Life	6 years
Depreciation	\$50,000 per year
Insurance	\$ 3,000 per year
<i>Interest</i>	<i>\$12,000 per year</i>

The yearly cost of ownership is \$65,000. It was determined that this was a ***virtual purchase***. The rental charge included in allowable expense is limited to \$65,000 and the difference of \$10,000 is deferred.²³

B. Medicare Audits

Additional guidance regarding Medicare audits can be found in the Medicare Financial Management Manual, CMS Pub.100-06 (“MFMM”), Chapter 8. The MFMM requires that the Medicare Contractor ensure during audits that the audited cost report is “in conformity with the Medicare principles of payment;”²⁴ and states that the auditor’s “primary goal is to arrive at a correct settlement of the cost report.”²⁵ It also notes that the auditing standards “require the contractor to plan and perform the audit to obtain reasonable assurance about whether the cost report reflects payment amounts and financial data in accordance with Medicare laws, regulations, and instructions.”²⁶ Further, in addressing the “Sources and Categories of Evidence, it notes that the evidence must be sufficient “to determine that proper payment is made for services provided to Medicare beneficiaries.”²⁷

C. Burden of Proof and Standard of Review

A Board “decision must include findings of fact and conclusions of law regarding . . . 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.”²⁸ 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, 217 (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

²³ (Bold and italics emphasis added).

²⁴ CMS Pub. 100-06, Chapter 8, § 30.1.

²⁵ *Id.* at § 30.2.

²⁶ *Id.* at § 70.1.

²⁷ *Id.* at § 60.7A.

²⁸ 42 C.F.R. § 405.1871(a)(3).

²⁹ 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).

support a conclusion.”³⁰ 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.”³¹

*D. Board Jurisdiction and Scope of Authority During the Time at Issue and the District Court’s Interpretation*³²

At the outset, the Board notes that 42 U.S.C. § 1395oo(f)(1)³³ the Provider has the right to appeal only to either the U.S. District Court in whose judicial district it is located (*i.e.*, the Southern District of Texas) or to that for the District of Columbia. Accordingly, it is apparent that decisions of the U.S. Court of Appeals for the D.C. Circuit and the 5th Circuit are binding for purposes of the Board’s analysis of jurisdiction as administrative agencies follow the law of the circuit whose courts have jurisdiction over the cause of action.³⁴

It is well-established that 42 U.S.C. 1395oo(a), provides the statutory basis for a Medicare-participating hospital to seek Board review of a final determination on its Medicare reimbursement for a given cost reporting period.³⁵ Under § 1395oo(a), if the hospital is “dissatisfied with a final determination” as to that reimbursement, the hospital may request a hearing before the Board if it timely filed (generally within 180 days after notice) and the amount in controversy is \$10,000 or more. During the time at issue, the Secretary implemented this statutory provision at 42 C.F.R. § 405.1835 (1996) which states, in pertinent part:

(a) *Criteria.* The provider (but no other individual, entity, or party) has a right to a hearing before the Board about any matter designated in § 405.1801(a)(1), if:

(1) An intermediary determination has been made with respect to the provider; and

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 In the final rule issued on May 23, 2008, the Secretary made significant revisions to the Board’s governing regulations. 73 Fed. Reg. 30190 (May 23, 2008). As part of this final rule, the Secretary addressed the Supreme Court’s decision in *Bethesda Hosp. Ass’n v. Bowen*, 485 U.S. 399 (1988) and revised its regulations to specify that jurisdiction is issue specific.

³³ Codifying § 1878(f)(1) of the Social Security Act.

³⁴ To this end, the CMS Administrator generally has applied as controlling precedent the law of the Circuit in which the Provider is located. See, e.g., *QRS CHW DSH Labor room Days Groups v. Blue Cross Blue Shield Ass’n*, Adm’r Dec. (Apr. 13, 2009), affirming, PRRB Dec. No. 2009-D11 (Feb. 27, 2009); *St. Vincent Mercy Med. Ctr. v. BlueCross BlueShield Assn*, Adm’r Dec. (Nov. 17, 2008), *affirming in part and reversing in part*, PRRB Dec. No. 2008-D35 (Sept. 15, 2008). However, in recognizing that providers may file suit with the appropriate District Court either in the Circuit in which they are located or the D.C. Circuit, the Administrator also applies as controlling precedent the law of the D.C. Circuit. See, e.g., *Jordan Hosp. v. Blue Cross Blue Shield Ass’n*, Adm’r Dec. (Apr. 30, 2007), *vacating*, PRRB Dec. No. 2007-D23 (Feb. 28, 2007).

³⁵ 42 U.S.C. § 1395oo(a)(1)(A)(i) relates to the right to appeal final determinations of reimbursement under 42 U.S.C. § 1395x(v)(1)(A) (*i.e.*, reasonable cost reimbursement through the cost reporting process) and § 1395oo(a)(1)(ii) relates to certain rights to appeal final determinations on reimbursement under 42 U.S.C. § 1395ww(d) (*i.e.*, the inpatient prospective payment system) or under 42 U.S.C. § 1395ww(b) (*i.e.*, the TEFRA payment system).

(2) The provider has filed a written request for a hearing before the Board under the provisions described in § 405.1841(a)(1); and

(3) The amount in controversy (as determined in § 1839(a)) is \$10,000 or more.

(b) *Prospective payment exceptions.* Except with respect to matters for which administrative or judicial review is not permitted as specified in § 405.1804, hospitals that are paid under the prospective payment system are entitled to hearings before the Board under this section if they otherwise meet the criteria described in paragraph (a) of that section.

During the time at issue, 42 C.F.R. § 405.1841(a)(1) (1996) provided the following instructions for the content of a hearing request for an individual provider appeal:

The request for a Board hearing must be filed in writing with the Board within 180 days of the date the notice of the intermediary's determination was mailed to the provider or, where notice of the determination was not timely rendered, within 180 days after the expiration of the period specified in § 405.1835(c). ***Such request for Board hearing must identify the aspects of the determination with which the provider is dissatisfied, explain why the provider believes the determination is incorrect *in such particulars*, and be accompanied by any documenting evidence the provider considers necessary to support its position. Prior to the commencement of the hearing proceedings, the provider may identify in writing *additional aspects of the intermediary's determination* with which it is dissatisfied and furnish any documentary evidence in support thereof.***³⁶

In addition, 42 U.S.C. § 1395oo(d) addresses "Decisions of Board" and specifies:

A decision by the Board shall be based upon the record made at such hearing, which shall include the evidence considered by the intermediary 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. ***The 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.***³⁷

³⁶ (Emphasis added).

³⁷ (Emphasis added).

Finally, during the time at issue, 42 C.F.R. § 405.1873 (1996) addressed the “Board’s jurisdiction” and states, in pertinent part:

(a) *Board decides jurisdiction.* **The Board decides questions relating to its jurisdiction to grant a hearing,** including (1) the timeliness of an intermediary determination (see § 405.1835(c)), and (2) the right of a provider to a hearing before the Boards when the amount in controversy is in issue (see §§ 405.1835(a)(3) and 405.1837).³⁸

In its remand decision, the District Court describes how Board jurisdiction has been applied and the split amongst the Circuits:

Courts have interpreted the word “dissatisfied” to preclude **mandatory jurisdiction** where a provider “fails to request from the intermediary reimbursement for all costs to which it is entitled under applicable rules.” *Little Co. of Mary Hosp. & Health Care Centers v. Shalala*, 24 F.3d 984, 993 (7th Cir. 1994) (citing *Bethesda Hosp. Ass’n v. Bowen*, 485 U.S. 399, 405 (1988)). **This jurisdictional prerequisite ensures that a “hospital that does not ask its intermediary to reimburse it for all of the costs for which it is entitled to be reimbursed cannot, on appeal to the Board, first ask for new costs.”** *Id.* In general, a provider cannot appeal costs that it never requested from an intermediary because the intermediary never had the opportunity to review those costs in the first place. *See id.* Thus, there is no jurisdiction for appellate review. *Id.*

In *Bethesda Hospital Association v. Bowen*, the Supreme Court articulated an important exception to this general rule. 485 U.S. at 405. A hospital provider chose not to request certain costs from its intermediary because those costs were clearly disallowed under the Medicare guidelines. *Id.* at 401. On appeal, the provider tried to challenge those guidelines by requesting reimbursement for the unclaimed costs. *Id.* The Board found that the provider did not meet the jurisdictional prerequisite of being “dissatisfied” over the unclaimed costs because the provider did not request them in its cost report. *Id.* The Supreme Court reversed and held that “the submission of a cost report in full compliance with the unambiguous dictates of the Secretary’s rules and regulations does not, by itself, bar the provider from claiming dissatisfaction with the amount of reimbursement allowed by those regulations.” *Id.* at 405. Because the intermediary had no authority to stray from the Medicare guidelines put forth by the Secretary, the provider could

³⁸ (Bold and underline emphasis added and italics in original).

“self-disallow” uncovered costs by not including them in a cost report before later appealing those costs to the Board. *Id.*

The Supreme Court distinguished the situation where reporting unallowable costs “would be futile” from a scenario in which providers “fail to request from the intermediary reimbursement for all costs to which they are entitled under applicable rules.” *Id.* **According to the Court, such “defaults might well establish that a provider was satisfied with the amounts requested in its cost report and awarded by the fiscal intermediary.”** *Id.*

Several Circuit Courts have differed in how to interpret the Supreme Court's guidance in *Bethesda Hospital*. In *Little Company of Mary Hospital v. Shalala*, the Seventh Circuit concluded that § 139500(a) only confers jurisdiction over (1) costs that a provider reports to an intermediary; or (2) costs that are “self-disallowed” by a provider because presenting them to an intermediary would be futile. 24 F.3d 984, 993 (7th Cir. 1994). According to the Seventh Circuit, the Supreme Court in *Bethesda Hospital* “strongly hint[ed]” that “providers who fail to request from the intermediary reimbursement for all costs to which they are entitled under applicable rules ... should not be permitted to later claim to be ‘dissatisfied’ with the reimbursement [they] receive and thereby invoke the Board's jurisdiction.” *Id.* Thus, the Seventh Circuit held that costs that are omitted from a cost report by inadvertence or mistake are not subject to appellate review. *Id.*

The First and Ninth Circuits took a different approach. In *MaineGeneral Medical Center v. Shalala* and *Loma Linda University Medical Center v. Leavitt*, **the First and Ninth Circuits interpreted § 139500(a) as a “gateway” to establishing general jurisdiction over a cost report.** 205 F.3d 493, 497 (1st Cir. 2000); 492 F.3d 1065, 1068 (9th Cir. 2007). Drawing on the plain language of the statute, the courts concluded that providers that are “dissatisfied with a final determination ... as to the amount of total program reimbursement” are entitled to a hearing. *See, e.g., Loma Linda Univ. Med. Ctr.*, 492 F.3d at 1073 (quoting 42 U.S.C. § 139500(a)). Once a provider is “dissatisfied” with the “total program reimbursement,” the Board then has 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 ... even though such matters were not considered by the intermediary in making such final determination.” *Id.* (quoting 42 U.S.C. § 139500(d)). Thus, both the First and Ninth Circuits held that the Board has jurisdiction over claims not included in the initial cost report, even if they were

inadvertently or negligently omitted. *MaineGeneral Med. Ctr.*, 205 F.3d at 497; *Loma Linda Univ. Med. Ctr.*, 492 F.3d at 1068.³⁹

The District Court also gave the following description of the Secretary’s position on jurisdiction as well as the Board’s historical practice of not exercising its discretion under 42 U.S.C. § 1395oo(d) to review unclaimed costs:

The Secretary has adopted the position that the Board is not required to exercise jurisdiction over costs that were “inadvertently omitted or mistakenly reported on the cost report.” (Instrument No. 31-1 at 10). The District Court for the District of Columbia recently embraced this same opinion. In *Saint Vincent Indianapolis Hospital v. Sebelius*, the district court held that the Board’s decision not to exercise jurisdiction over costs that were negligently omitted from a cost report was “a permissible construction of the statute” under *Chevron*. 134 F. Supp. 3d 238, 242 (D.D.C. 2015). The Court explained that the plaintiff “failed to meet the jurisdiction[al] prerequisite of being ‘dissatisfied’ with the amount of Medicare payment because the ‘errors and omissions’ alleged by the provider in its appeal stemmed from its own ‘negligence in understanding the Medicare regulations governing the reimbursement of such costs’ rather than the FI/MAC’s action.” *Id.* at 241 (internal citations omitted).⁴⁰

Subsequent to the D.C. District Court’s remand, the D.C. Circuit addressed the Circuit split in the context of an unpublished 2025 decision, *University of Chicago Medical Center v. Kennedy* (“*UChicago*”).⁴¹ While it was not necessary for the D.C. Circuit to take a position on the Circuit split in order to resolve the matter before it, it did affirm the Board’s general policy of not hearing claims under § 1395oo(d) when those claims are not raised before the Medicare contractor:

The Board’s general policy of not hearing claims under § 1395oo(d) when those claims are not raised before the financial intermediary – the contractor – is sensible. The statutory scheme does not designate the Board as a body of first impression. Its policy encourages providers to be diligent in preparing their cost reports. This policy is not a new substantive legal standard that had to be “promulgated ... by regulation” under 42 U.S.C. § 1395hh(a)(2) because it does not impose new financial obligations on providers or alter any formulae used to determine reimbursement. *See Clarian Health W., LLC v. Hargan*, 878 F.3d 346, 356 (D.C. Cir. 2017); *see also Chippewa Dialysis Servs. v.*

³⁹ Provider’s CFPP Ex. P-7 at 9-12 (bold and underline emphasis added).

⁴⁰ *Id.* at 12.

⁴¹ No. 24-5188, 2025 WL 3183158 (D.C. Cir. Nov. 14, 2025), *aff’g* No. 16-cv-1276, 2024 WL 3181308 (D.D.C. Jun. 26, 2024).

Leavitt, 511 F.3d 172, 177 (D.C. Cir. 2007). It merely establishes a procedural requirement providers must satisfy before the Board will exercise its discretionary authority to hear challenges concerning existing substantive legal standards. The Board could establish such a procedural requirement in case-by-case adjudications. *See Bell Aerospace Co.*, 416 U.S. at 290–95. For the same reason, the requirement did not need to be published in the Federal Register under 42 U.S.C. § 1395hh(c)(1). The Medicare Statute empowers the Board to “establish procedures ... necessary or appropriate to carry out the provisions of this section.” 42 U.S.C. § 1395oo(e). The formulation of procedures is within the discretion of agencies to which Congress has confided the responsibility for substantive judgments. *See Vt. Yankee Nuclear Power Corp. v. Nat. Res. Def. Council, Inc.*, 435 U.S. 519, 542–48 (1978).⁴²

Finally, the District Court explained how the jurisdictional issue before the Board is potentially novel and how it would apply 42 U.S.C. § 1395oo(a) if the Board were to find that Memorial City is not at fault for the capital lease interest cost not being claimed on the cost reports at issue and that the fault lies instead with the Medicare Contractor:

Courts have not directly addressed the question of whether § 1395oo(a) requires mandatory jurisdiction whenever a provider makes a mistake on a cost report due to erroneous guidance from a MAC. However, **all of the cases in which the Board had the authority to decline to exercise jurisdiction concerned situations in which omissions or mistakes in cost reports were attributed to a provider's own negligence.** *See, e.g., Little Company of Mary Hospital v. Shalala*, 24 F.3d 984, 993 (7th Cir. 1994). In *Saint Vincent Indianapolis Hospital*, the district court differentiated these scenarios from those in which the MAC is at fault. 134 F. Supp. 3d 238, 241 (D.D.C. 2015). The court explained that a provider could not be “dissatisfied” within the meaning of § 1395oo(a) where errors and omissions on a cost report stem from the provider's “own negligence in understanding the Medicare regulations governing the reimbursement of such costs *rather than the FI/MAC's action.*” *Id.* (emphasis added).

Based on the plain language of the statute, a provider who receives false information from its MAC would likely be “dissatisfied” with the “final determination of the organization serving as its fiscal intermediary.” *See* 42 U.S.C. § 1395oo(a)(1). In *Bethesda Hospital*, the Supreme Court explained that “defaults [and omissions] might well establish that a provider was satisfied with the amounts requested in its cost report and awarded by the fiscal intermediary.” 485 U.S. at 405. If the intermediary itself is at

⁴² *Id.* at *2 (bold and underline emphasis added).

fault, however, then any reasonable provider would be “dissatisfied” with the intermediary. If the intermediary provides erroneous guidance to a provider that adversely affects its reimbursement, then the provider's only recourse is to appeal to the Board. Section 1395oo establishes a mechanism for the Board to review any actions and omissions made by the intermediary, “even though such matters were not considered by the intermediary in making such final determination.” *See* 42 U.S.C. § 1395oo(d). Thus, a provider who is “dissatisfied” with the actions taken by the intermediary and the “amount of total program reimbursement” has a right to a hearing before the Board.⁴³

STATEMENT OF RELATIVE FACTS:

The parties filed a Joint Stipulation of Facts, dated October 26, 2023, which stipulated that “[t]he financing cost arising from the implicit interest in the lease was not calculated and was not included in the costs of ownership in Worksheet A for the Cost Years at issue in this Appeal.”⁴⁴ However, to date, the Provider asserts that the interest was not included on Worksheet A due to its reliance on erroneous guidance provided by the Medicare Contractor.⁴⁵

The Parties further stipulated, in pertinent parts, as follows:

I. Background Facts

* * *

4. The Parties agree that the lease of Provider’s assets is a capital lease or virtual purchase (those two terms are being used synonymously) and was treated in part as such by both Provider and the MAC for Medicare cost reporting purposes. Lease payments in the amount of \$26.1 million, which were originally included in the costs shown on Worksheet A, were offset on Worksheet A-8. Depreciation costs based on those of the prior owner (Metro) were added by a Worksheet A-8 adjustment. There is no dispute between the Parties about the accuracy of the depreciation or other figures in the audited cost reports. 2008 Stipulations ¶ 3.

5. The financing cost arising from the implicit interest in the lease was not calculated and was not included in the costs of ownership in Worksheet A for the Cost Years at issue in this Appeal. *See* Exhibit P-22 to Provider’s Final Position Paper; Exhibit P-27 to Provider’s Final Position Paper; Exhibit P-32 to Provider’s Final Position Paper; Exhibit P-38 to Provider’s Final Position Paper.

6. The MAC audited the cost reports for the Cost Years at issue and adjusted the capital costs; thus, the MAC was fully aware that the lease was being treated as a capital lease, as opposed to an operating lease. *See* Exhibit P-11 to Provider’s Responsive Brief filed

⁴³ Provider’s CFPP Ex. P-7 at 14-15 (bold and underline emphasis added).

⁴⁴ 2023 Stip. at ¶ 5.

⁴⁵ *See id.* at ¶ 9.

on December 20, 2021 (“Provider’s Responsive Brief”); Exhibit P-12 to Provider’s Responsive Brief; Exhibit P-13 to Provider’s Responsive Brief.

7. According to the MAC, the only issue the Board needs to decide in this Appeal is whether the Provider must present additional proof to establish that incorrect advice that was provided by the MAC caused the omission of the implicit interest in the Lease payments on the Provider’s cost reports for the Cost Years at issue.

8. In 2008, the Board heard testimony (“2008 Board Hearing”) with respect to the cost years 1994, 1995, 1997, and 1999 (“first set of cost years”) that addressed the exact same issue in this Appeal: the reimbursement of Provider for the interest (financing cost) implicit in the payments for a “capital lease” or “virtual purchase.” *See* Exhibit P-6 to Provider’s Responsive Brief.

9. During the 2008 Board Hearing, the Provider’s witness, Helen Savitzky, provided sworn testimony, subject to cross-examination by both the MAC and the Board, that the MAC supplied “incorrect or incomplete” guidance to Provider that caused the omission of the implicit interest of the lease as a cost of ownership on the cost reports for the Cost Years at issue in this Appeal. Exhibit P-9 to Provider’s Responsive Brief; *see also* Exhibit P-6 to Provider’s Responsive Brief. In Miss Savitzky’s testimony at the Board hearing, she testified she had not been able to locate any written confirmation of the “incorrect” or “incomplete” discussion. Exhibit P-6 to Provider’s Responsive Brief at 32 and 38. The MAC did not present any witnesses or documentary evidence to contradict Ms. Savitzky’s sworn testimony. *See* Exhibit P-6 to Provider’s Responsive Brief.

10. Provider’s witness, Ms. Savitzky, has confirmed in a December 17, 2021 declaration that her testimony during the 2008 Board Hearing also applies to the Cost Years at issue in this Appeal. Exhibit P-9 to Provider’s Responsive Brief.

11. The Parties agree to incorporate Exhibit P-9 to Provider’s Responsive Brief (Declaration of H. Savitzky (Dec. 17, 2021)) into this Stipulation. *See* Exhibit P-9 to Provider’s Responsive Brief.

* * *

II. The Calculations

13. The Parties agree that imputed interest is a reasonable cost of ownership pursuant to 42 C.F.R. § 413.130(b)(9) and PRM-I § 110.B when a lease is considered to be a capital lease or virtual purchase. 2008 Stipulations ¶ 4.

* * *

16. The Provider and MAC agree that should the Board find that it has jurisdiction over the dispute, the correct amount of Medicare Reimbursement should be determined by CMS as reflected above in paragraph 15.⁴⁶

⁴⁶ 2023 Stip.

DISCUSSION, FINDINGS OF FACT, AND CONCLUSIONS OF LAW:

It is undisputed that Memorial City's assets were treated as a capital lease or virtual purchase by both the Provider and the Medicare Contractor for the years at issue in this appeal. Additionally, it is similarly undisputed that implicit interest was not claimed on the cost report.⁴⁷ However, unresolved is the question of fact: Whether the Provider's own error caused the omission of the interest sought for reimbursement or if the fault lies with the Medicare Contractor because it provided erroneous guidance upon which the Provider relied to its detriment.⁴⁸ More specifically, does the record before the Board substantiate the Provider's allegation that the Medicare Contractor provided guidance or instructions that the Provider should not include or claim the interest incurred on the capital lease in the cost reports for the years at issue?⁴⁹ Notwithstanding the genuine issue of material fact, the overarching question of law is whether the Board has jurisdiction over the unclaimed costs at issue herein.⁵⁰

42 U.S.C. § 1395oo(a) dictates that to obtain jurisdiction, a provider must be "dissatisfied" with a "final determination" of the Medicare contractor. Thus, it follows that a provider must have claimed reimbursement for items and services for the Medicare contractor to make a "final determination" regarding such items and services.

As noted in its original jurisdictional determinations for these cases, "[t]he Board has generally interpreted [42 U.S.C.] § 1395oo(a) as: (1) the gateway to establishing Board jurisdiction to hear an appeal; and (2) . . . requiring that dissatisfaction be expressed with respect to the total reimbursement for 'each claim' (as opposed to a general dissatisfaction to the total reimbursement on the NPR) because the Board has viewed the NPR as being comprised of many individual determinations on various items for which the provider has sought payment in the as-filed cost report."⁵¹ After jurisdiction is established under § 1395oo(a), the Board has the discretionary power to make a determination on all matters covered by the cost report (including ones not considered by the Medicare contractor). Accordingly, the Board has generally found that "only when the provider has established jurisdiction under § 1395oo(a) with respect to one or more such claims/issues can the Board then exercise [its] discretion [under § 1395oo(d)] to hear other claims not considered by the intermediary (*e.g.*, unclaimed costs)."⁵²

In the instant cases, Memorial City failed to claim the implicit interest it now seeks. It is clear in the instant cases that gateway jurisdiction under 42 U.S.C. § 1395(a) has been established ***over the NPR at issue***⁵³ in each of these cases because the Provider did file a jurisdictionally valid

⁴⁷ *Id.* at ¶¶ 4, 5.

⁴⁸ Provider's CFPP Ex. P-7 at 5-6, 13-15.

⁴⁹ *Id.*

⁵⁰ *See id.* at 2; *see also* Medicare Contractor's CFPP at 5.

⁵¹ Provider's CRB Ex. P-3 at P51. *See also Affinity Med. Ctr. v. BlueCross BlueShield Ass'n*, PRRB Dec. No. 2010-D15 (Mar. 11, 2010), *decl'd review*, CMS Adm'r. (May 3, 2010) (analyzing a provider's right to a hearing on an issue-specific basis rather than a general basis) ("*Affinity*, PRRB 2010-D15").

⁵² *Id.*

⁵³ This encompasses the NPR package that includes the audit adjustment report and the audited cost report reflecting adjustments made to the items claimed on the cost report. Thus, a provider's § 1395oo(a) dissatisfaction generally stems from the Medicare Contractor's audit of the as-filed cost report and the resulting differences between its as-filed and audited cost report. The instant cases are different in that they involve costs ***not*** claimed on the cost report.

appeal for dissatisfaction with issues other than the capital lease interest issue. Given that gateway jurisdiction over the NPRs at issue has been established, it is moot to revisit the legal question of: (1) whether “dissatisfaction” under 42 U.S.C. § 1395oo(a) applies only to the total amount of program reimbursement reflected on the NPR; or (2) in the alternative, whether “dissatisfaction” needs to be tied to a specific gateway claim in these cases because it is clear that Memorial City’s appeal request for each of the fiscal years at issue did include other issues which the Medicare Contractor did consider. As a result, **for purposes of this decision**, the Board need not revisit that legal issue because, under either approach, gateway jurisdiction under § 1395(a) has been established and because the Secretary’s position on this point has been made clear to the District Court.⁵⁴ Further, once that gateway jurisdiction has been established, courts have generally upheld the Board’s position that it has discretion (*i.e.*, is not required) under § 1395oo(d) as to whether it will hear unclaimed costs not raised before and considered by the Medicare Contractor.⁵⁵

Consistent with the District Court’s Remand Order, the Board is focused on determining whether the Provider or the Medicare Contractor was at fault for the unclaimed costs at issue not being included on the cost reports for FYs 1996, 1998, 2000 and 2001. If the Board determines that the Medicare Contractor is at fault, the District Court directs the Board to address the novel issue of whether § 1395(a) requires mandatory jurisdiction when the Provider makes a mistake on a cost report due to the fault of the Medicare Contractor (as opposed to the Provider).⁵⁶ If the

⁵⁴ The D.C. Circuit was faced with a similar situation in the *UChicago* decision and determined that it need not resolve which approach to adopt as each gave the same result under the facts before the Court. *UChicago*, 2025 WL 3183158 at *1-2 (discussing the approach of the Seventh Circuit in juxtaposition to that of the First and Ninth Circuits). The opinion of the dissenting Board Member (dissenting in part and concurring in part) fails to consider the Secretary’s position on jurisdiction or appreciate that *Adams House* is irrelevant due to the fact that Memorial City appealed other items that establish the Board’s general gateway jurisdiction. As a result, the questions on remand are whether there is *mandatory* Board jurisdiction over the implicit capital interest costs at issue under § 1395oo(a) based on the novel theory posed by the District Court (*see infra* note 56); and, if the novel question is not reached, whether the Board will exercise its discretion under § 1395oo(d) to hear the unclaimed costs at issue.

⁵⁵ *See supra* note 41 and accompanying text quoting the D.C. Circuit’s 2025 *UChicago* decision. *See also Little Co. of Mary Hosp. and Health Care Ctrs. v. Shalala*, 165 F.3d 1162, 1165 (7th Cir. 1999) (“The board is allowed to review a ruling by a fiscal intermediary only if the provider (the hospital in this case) ‘is dissatisfied with a final determination of the ... fiscal intermediary ... as to the amount of total program reimbursement due the provider’ 42 U.S.C. § 1395oo(a)(1)(A)(i). The hospital points out that it was dissatisfied, albeit not on the ground that it had presented to the intermediary. But while the statute is curiously worded, the intent is plain that the provider must give the intermediary a first shot at the issue, provided the issue is within the intermediary’s competence, as the issue of deducting the land loss against the investment income was because it did not involve an issue of policy.” (case citations omitted)); *MaineGeneral*, 205 F.3d at 500 (First Circuit affirming: “the Board has statutory jurisdiction to hear claims not first raised before the intermediary, but it may decline to do so as a matter of discretion”); *Loma Linda*, 492 F.3d at 1068 (Ninth Circuit stating: “We conclude that once the Board acquires jurisdiction pursuant to 42 U.S.C. § 1395oo(a) over a dissatisfied provider’s cost report on appeal from the intermediary’s final determination of total reimbursement due for a covered year, it has discretion under § 1395oo(d) to decide whether to order reimbursement of a cost or expense that was incurred within the period for which the cost report was filed, even though that particular expense was not expressly claimed or explicitly considered by the intermediary. In this, we join the First Circuit’s similar view.” (footnotes and citations omitted)); *Saint Vincent Indianapolis Hosp. v. Sebelius*, 134 F. Supp. 3d 238, 242 (D.D.C. 2015) (upholding the Board’s decision to not exercise jurisdiction over costs that were negligently omitted from the cost report as a “permissible construction of the statute”); *UMDNJ-University Hosp. v. Leavitt*, 439 F. Supp. 2d 70, 78-79 (D.D.C. 2000).

⁵⁶ Provider’s CFPP Ex. P-7 at 14-15 (remand order stating: “Courts have not directly addressed the question of whether § 1395oo(a) requires **mandatory jurisdiction** whenever a provider makes on a mistake on a cost report due to erroneous guidance from a MAC” (emphasis added)). Contrary to the opinion of the dissenting Board Member,

Board finds that the Provider (as opposed to the Medicare Contractor) is at fault, then the Board must revisit whether it will exercise its discretion under 42 U.S.C. § 1395oo(d) to hear the unclaimed cost at issue (*i.e.*, the capital lease interest costs at issue).

As discussed below, based on its review of the parties' arguments, the evidence presented, and applicable Medicare law, regulations and guidance, the Board Majority: (1) finds that the Provider was at fault for the capital lease interest cost not being claimed on its cost reports for the fiscal years at issue and, thus, did not have the right to *directly* appeal the unclaimed capital lease interest issue under § 1395oo(a) (*i.e.*, there is no mandatory jurisdiction over this issue); and (2) declines to exercise its discretion under 42 U.S.C. § 1395oo(d) to hear the appeal of the unclaimed costs of capital lease interest when reimbursement of those costs was *not* precluded by a specific law, regulation, CMS Ruling or manual instruction (and again when the fault for the costs not being claimed lies with the Provider).⁵⁷ In making these findings, the Board in particular took under consideration: (1) the Provider's claim that it received erroneous guidance from the Medicare Contractor regarding whether it could claim the implicit interest cost on its cost reports; (2) the Medicare Contractor's opposition to the Provider's position; and (3) the testimony of the Provider's witness, Ms. Savitzky. The Board summarizes each of these as follows:

A. MEMORIAL CITY'S POSITION:

Memorial City contends that in March of 1994 around the time of the transaction, they discussed with the Medicare Contractor how to treat the lease on the Medicare cost report.⁵⁸ Specifically, Memorial City asserts:

[t]he [Medicare Contractor] informed Provider not to claim the actual lease payments on the cost report, as would be done for an operating lease. Instead, the [Medicare Contractor] told the Provider to offset the lease payments on Worksheet A-8, and to claim depreciation costs based on the historical netbook value of the assets that were leased. *See* Transcript, PRRB Case Nos. 98-2218, 98-2219, 01-2534, and 03-1358 (Dec. 18, 2008) 116:7-18, 117:1-7 ["Transcript"] (Exhibit P-12). In other words, the [Medicare Contractor] instructed Provider to treat the lease as a virtual purchase, or a capital lease, rather than as an operating lease.⁵⁹

the Board Majority is focused on the *novel* question posed by the District Court because whether the Board reaches that question hinges on whether the Board finds that the Medicare Contractor was at fault for the costs at issue being unclaimed on the cost reports at issue. If, instead, the Board finds Memorial City was at fault, then the fact scenario is the plain vanilla unclaimed cost scenario described by the District Court: "all of the cases in which the Board had authority to decline to exercise jurisdiction concerned situations in which omissions or mistakes in cost reports were attributed to a provider's own negligence." Ex. P-7 at 14 (citations omitted).

⁵⁷ This declination is consistent with how the Board has historically approached its discretion under § 1395oo(d).

As recognized by the District Court in its remand order (Ex. P-7 at 14), the Board has routinely declined to exercise its discretion under 42 U.S.C. § 1395(d) to hear unclaimed costs. *See also, e.g., Affinity*, PRRB 2010-D15.

⁵⁸ Provider's CFPP at 5.

⁵⁹ *Id.*

Nonetheless, Memorial City also asserts that for each cost year from 1994 onwards, other costs of ownership were directly incurred and claimed on the cost report, “such as real estate taxes, building insurance, and maintenance and repairs.”⁶⁰ However, Memorial City claims that the total costs were understated because “implicit financing costs were not reimbursed.”⁶¹ Furthermore, the Provider contends that the issue in the instant matter “does not involve any new cost not previously claimed, but rather a correction to include the implicit financing cost of the previously claimed ‘costs of ownership’ for the leased assets.”⁶²

Memorial City argues that the Medicare Contractor audited capital costs on its cost reports and was aware that the lease was treated as a capital lease, not an operating lease.⁶³ Despite this, the Provider contends that the Medicare Contractor did not correct the omission of the implicit interest of the lease payments on Memorial City’s cost reports. Thus, the Provider reasons that since the omissions were “caused” by the Medicare Contractor, the Board has jurisdiction over the disputes as to the proper calculation of the lease payments on the cost report.⁶⁴

In addition, Memorial City refutes the Medicare Contractor’s claims that it is required to present additional proof of the Medicare Contractor’s faulty instructions with respect to the handling of implicit interest on the lease payments for the cost years at issue. Memorial City states that, on remand, “the Court asked the Board to review ‘the question of whether the [Provider] or [Medicare Contractor] caused the omissions on [Provider’s] cost reports,’ as to which there is already substantial and uncontroverted evidence.”⁶⁵ Also, Memorial City notes the following:

[i]n the Order remanding this case, the Court specifically noted that Provider pointed to a 2008 Board hearing transcript (the same transcript cited in Provider’s Final Position Paper) to support its contention that the [Medicare Contractor] supplied erroneous instructions. *Id.* at 13 (“Plaintiff raised the issue of erroneous guidance from the [Medicare Contractor] at a hearing before the Board in December 2008.”) (citation omitted) (Exhibit P-1 at P13). The Court did not further address Provider’s evidence because the Board failed to consider that evidence to support its jurisdictional decisions. *See* Board Decision, PRRB Case Nos.: 01-2533, 01-2535, and 03-1411 at 9-10 (Sept. 12, 2014) (Exhibit P-3 at P51-52); Board Decision, PRRB Case No.: 04-2243 at 3-4 (Nov. 15, 2017) (Exhibit P-4 at P75-76). . . . The Court did not, however, state that this evidence was not already available for the Board’s consideration.⁶⁶

The Provider argues that its evidence “confirms that the [Medicare Contractor] caused the omissions to Provider’s cost reports.”⁶⁷ Memorial City further contends that its sworn testimony

⁶⁰ *Id.* at 6.

⁶¹ *Id.*

⁶² *Id.*

⁶³ *See id.* at 6-7.

⁶⁴ Provider’s CRB at 6-7.

⁶⁵ *Id.* at 3.

⁶⁶ *Id.*

⁶⁷ *Id.*

“unequivocally confirms that Provider relied on the [Medicare Contractor’s] incorrect instructions in completing its cost reports.”⁶⁸ Further, Memorial City argues that there is no evidence to the contrary as the Medicare Contractor did not present rebuttal testimony during the 2008 hearing, and therefore, the Provider contends that “the evidence is clear that the [Medicare Contractor] caused Provider’s cost report omissions.”⁶⁹

Finally, in response to the Medicare Contractor’s request for written correspondence documenting the alleged guidance or incorrect instructions in 1994, Memorial City admits that “there is no known documentation of this issue,” but argues that the Medicare Contractor “has never disputed Ms. Savitzky’s sworn testimony of what the [Medicare Contractor] told Provider.”⁷⁰ The Provider argues, therefore, that “this uncontroverted testimony requires the Board to find that the [Medicare Contractor] is responsible for Provider’s reporting, and as a result, remand this case to the [Medicare Contractor] to reimburse Provider for its costs of implicit interest in the lease payments.”⁷¹

B. MEDICARE CONTRACTOR’S POSITION:

The Medicare Contractor contends that, given the main question before the Board - “whether the Plaintiff or [Medicare Contractor] caused the omissions on Plaintiff’s cost reports,”⁷² – the Provider is obligated to present sufficient evidence demonstrating that the Medicare Contractor was responsible for the omission, but has failed to do so.⁷³ The Medicare Contractor points out that, in the testimony during the 2008 hearing, when asked on cross-examination whether the instruction in question was “reflected in any type of correspondence,” the witness replied “[n]one that I’ve been able to locate.”⁷⁴ The Medicare Contractor argues that the Provider concludes that the answer to the Court’s question is that the Medicare Contractor is at fault for the omissions, but “presents no argument or evidence to support this conclusion.”⁷⁵

The Medicare Contractor also argues that neither the Stipulations associated with the Board Hearing in Case Nos. 98-2219 (FYE 6/30/1994), 98-2218 (FYE 6/30/1995), 01-2524 (FYE 6/30/1997, and 03-1358 (FYE 6/30/1999) nor the Settlement Agreement claimed that the Medicare Contractor issued faulty or erroneous guidance.⁷⁶ Taking note of the District Court’s reference to the settlement of the case involving fiscal years 1994, 1995, 1997, and 1999, the Medicare Contractor puts forth two possibilities in relation to the remand of the instant matters. Either, 1) the Court was unaware of the earlier settlement, or 2) the Court was aware of the earlier settlement and “honored the Secretary’s denial of liability” but decided to require further

⁶⁸ *Id.* at 4.

⁶⁹ *Id.*

⁷⁰ *Id.* at 6.

⁷¹ *Id.*

⁷² Medicare Contractor’s CFPP at 8. *See also* Provider’s CFPP Ex. P-7 at 15, where the District Court states “[a]nd because the question of whether the Plaintiff or MAC caused the omissions on the Plaintiff’s cost reports is a genuine issue of material fact, the case must be remanded to the Board for further proceedings.”)

⁷³ *Id.*

⁷⁴ Provider’s CFPP Ex. P-12 (Transcript of Dec. 18, 2008 Hearing) at 124:8 – 11 (For clarity, the Board has cited to the actual Transcript pages, as needed, rather than the Exhibit pagination.).

⁷⁵ Medicare Contractor’s CFPP at 8.

⁷⁶ *Id.* at 7. *See also* Provider’s CFPP Ex. P-2 and Ex. P-4.

review by the Board of Memorial City's claim that "it was misled by the [Medicare Contractor] into taking actions against its interests."⁷⁷

Finally, the Medicare Contractor argues that it cannot prove a negative and that the burden of proof rests with Memorial City to provide proof of improper instructions given by the Medicare Contractor. The Medicare Contractor contends the Provider has not proven its assumption.⁷⁸

C. 2008 HEARING TESTIMONY:

The Board's fact finding in this case necessitated a review of the evidence in this case and, in particular, a closer review of the transcript from the 2008 Board Hearing.⁷⁹ One of the Provider's witnesses at the 2008 hearing, Helen Savitzky, worked for Memorial City General Hospital, until January 1, 1994, *when the facility was leased to Memorial Hermann*. Ms. Savitzky handled cost reporting for the Provider both before and after the lease started in January of 1994.⁸⁰ On direct examination, Ms. Savitzky recalled that, in March of 1994, the Provider contacted the former Medicare Contractor (*i.e.* "fiscal intermediary" or "FI") for guidance:

Q. And what did the FI say you should do regarding the lease payment itself?

A. The FI instructed us that the lease payments needed to be offset.

Q. And were there costs that it indicated you could claim?

A. The FI indicated that we could only add in the depreciation that was associated with the prior owner's assets.⁸¹

When asked about claiming interest on a capital lease, Ms. Savitzky responded:

Q. Did they ever tell you that you could claim interest on a capital lease?

A. No.⁸²

When questioned about costs of ownership, the following exchange took place:

Q. And, in general, are costs of ownership claimed in Memorial City's cost report?

⁷⁷ *Id.* at 8.

⁷⁸ *See id.*

⁷⁹ Provider's CFPP Ex. P-12.

⁸⁰ *Id.* at 113-114.

⁸¹ *Id.* at 116:7-18.

⁸² *Id.* at 118:14-17.

A. Yes.

Q. And depreciation is on there definitely, correct?

A. Correct.

Q. What about maintenance, taxes, and insurance? Are they on the cost report as well and claimed?

A. Yes, they are.⁸³

When Ms. Savitzky was cross-examined on her testimony, the following exchange took place:

Q. To the best of your recollection, ***did you specifically*** or did someone on your staff specifically ***ask Mr. Kenny can we include a financing or implicit or imputed interest cost? Do you remember that question being asked?***

A. ***No, I do not.***⁸⁴

Upon further cross examination, the following exchange took place:

Q. And has the hospital ever used a protested item mechanism or this hospital to express its dissatisfaction with reimbursement treatment?

A. Yes.

Q. But decided not to use it here because of this conversation with Mr. Kenny.

A. Correct.

Q. Was this reflected in any type of correspondence?

A. ***None that I've been able to locate.***⁸⁵

When asked on re-direct examination for clarification on specifically asking the FI about including imputed interest cost, Ms. Savitzky responded:

A. ***I do not recall any discussion related to that type of topic.***⁸⁶

⁸³ *Id.* at 121:16-122:1.

⁸⁴ *Id.* at 122:20-123:2 (emphasis added).

⁸⁵ *Id.* at 123:23-124:11 (emphasis added).

⁸⁶ *Id.* at 126:21-23 (emphasis added).

Under Board questioning by Board Member Richards, the following exchange transpired:

Mr. Richards: Based upon your knowledge at the time when he instructed you just to put the previous owner's depreciation on that cost report, did you challenge that at all or did you believe that to be the truth?

Mr. Savitzky: We believed that to be the truth.

Mr. Richards: Okay. If he instructed you just to put the depreciation expense on the cost report, ***why did you then add maintenance, taxes, and insurance?***

Ms. Savitzky: The maintenance, taxes, and insurance were already on the cost report because as Mr. Loria testified, it was a triple net lease and those costs had already been incurred by the hospital directly. So those costs were already on the cost report and it was my understanding that those were the responsibility of the hospital to pay.

Mr. Richards: So you don't think his limiting language to just depreciation expense would limit those other costs of ownership?

Ms. Savitzky: Not based on my understanding of how the lease was supposed to work.

Mr. Richards: ***So why would it limit interest expense if it didn't limit those other costs of ownership to depreciation?***

Ms. Savitzky: My understanding of the lease was that those items were very specifically identified and those were the only items that were specifically identified.

Mr. Richards: When did you first become aware that this accounting on the cost report was incorrect, if you recall?

Ms. Savitzky: I don't recall specifically. It was brought to my attention sometime in about 2003.

Mr. Richards: And who brought it to your attention?

Ms. Savitzky: My direct supervisor.

Mr. Richards: Okay. And what happened at that time when they brought it your attention? What did you do?

Ms. Savitzky: We had already begun to work with Mr. Loria. We had discussions with Mr. Loria about how best to treat this particular issue, which is when the reopenings were filed and the addition of this issue to open cost report appeals were added.⁸⁷

* * *

Mr. Richards: I have one other question or one type of question. When you get advice from the Intermediary, is it the policy of the hospital not to question it or is it because of this person's title, or why didn't you question what he said?

Ms. Savitzky: **This was such an unusual transaction**, we had no real knowledge how to handle it, and so our conversation with the Intermediary was for guidance and we believed the guidance that we received.⁸⁸

D. FINDINGS OF FACT AND CONCLUSIONS OF LAW:

At the outset, the Board notes that both the CMS regulations and the CMS Manual instructions clearly state that interest is allowable in the cost of ownership in this situation. Memorial City's claim that the Medicare Contractor instructed it to only claim depreciation costs is not supported by verifiable evidence. Upon reviewing the record, the Board finds that Memorial City offers no additional or corroborating evidence beyond witness testimony from the 2008 Hearing to support its claim that the Medicare Contractor provided incorrect or incomplete verbal instructions in March of 1994.

Memorial City states in its responsive final position paper that "there is no known documentation"⁸⁹ of these March 1994 instructions and, as such, at best, they appear to be oral instructions. Similarly, Ms. Savitzky, the Provider's witness at the 2008 Hearing, also testified that she had been unable to find any correspondence to document these March 1994 instructions.⁹⁰ Further, her testimony also indicates that there was no specific inquiry or conversation regarding the inclusion or exclusion of implicit interest on the Memorial City's cost reports.⁹¹

First, the Board does not find Ms. Savitzky's testimony to be persuasive that the Medicare Contractor caused Memorial City to omit the interest cost at issue from the cost reports at issue for FYs 1996, 1998, 2000, and 2001. Specifically, Ms. Savitzky's testimony illustrates that she understood the lease structure well enough to include maintenance, taxes, and insurance on the cost report.⁹² The Board shares Board Member Richards' skepticism: if the Provider was

⁸⁷ *Id.* at 127:30-130:24 (emphasis added).

⁸⁸ *Id.* at 132:3-19 (emphasis added).

⁸⁹ Provider's CRB at 6.

⁹⁰ *See* Provider's CFPP Ex. P-12 at 124.

⁹¹ *See id.* at 122-123.

⁹² *Id.* at 127-129.

instructed to **only** include depreciation as a cost of ownership, why were those other costs added?

Second, Ms. Savitzky acknowledged in her testimony that this was an “unusual transaction,”⁹³ so much so that the Provider sought guidance from the Medicare Contractor. It is difficult to believe that Memorial City would have made the effort to contact the Medicare Contractor for guidance without documenting the oral response, given that the proper cost report treatment of the costs of ownership related to the lease transaction is an issue with *long-term* implications across multiple fiscal years. Without evidence of the specific questions posed to the Medicare Contractor or proof of the responses provided, the Board remains unconvinced that the Medicare Contractor’s instruction was as unequivocal as you can “**only** claim depreciation costs associated with the prior owner,”⁹⁴ particularly when that is **not** what Memorial City did as evidenced by the fact that, in addition to the depreciation costs, Memorial City claimed maintenance, taxes, and insurance costs.⁹⁵

Moreover, in its Consolidated Final Position Paper, Memorial City acknowledges that the Medicare Contractor instructed the Provider to treat the lease in question *as a capital lease*: “In other words, the [Medicare Contractor] instructed the Provider to treat the lease as a virtual purchase, or a capital lease, rather than as an operating lease.”⁹⁶ As set forth in the Relevant Law Section above, *since 1992*, 42 C.F.R. § 413.130(b)(9)(i), relative to virtual purchases, has specifically stated, “The cost of ownership includes straight-line depreciation, insurance, **and interest**.”⁹⁷ And even as early as 1967, before the amendment of 42 C.F.R. § 413.130 to specifically address virtual purchases, § 110(B) has always listed “interest” along with straight-line depreciation and insurance in the potential allowable costs. Accordingly, the long-standing regulatory language and guidance regarding costs of ownership associated with virtual purchases were publicly available to Memorial City long before the earliest fiscal year at issue in this appeal (*i.e.*, 1996).⁹⁸ Thus, it is clear that Memorial City is a provider who failed to request from the Medicare Contractor reimbursement for all costs to which they are entitled under applicable Medicare rules permitting reimbursement of interest associated with capital leases.⁹⁹

Finally, the Board recognizes that, in its Consolidated Responsive Brief, the Provider briefly argues that, by adjusting capital costs per the Audit Adjustment Report, “the MAC was fully aware that the lease was being treated as a capital lease, as opposed to an operating lease” and that the Medicare Contractor failed “to correct the omission of the implicit interest of the lease payments on Provider’s cost reports.”¹⁰⁰

⁹³ *Id.* at 132:13-14.

⁹⁴ *Id.* at 123:20-22.

⁹⁵ Also, the fact that Ms. Savitzky learned of Memorial City’s error from her supervisor (*i.e.*, learned from her supervisor that interest could and should be claimed) suggests that Memorial City should have known it could claim the capital lease interest cost. See *supra* note 87 and accompanying text.

⁹⁶ Provider’s CFPP at 5.

⁹⁷ (Emphasis added).

⁹⁸ This fact suggests that, to the extent the March 1994 instructions were given, Memorial City’s witness may have misunderstood them. It further highlights the importance of obtaining instructions (or follow-up confirmation thereof) **in writing**, particularly when her understanding of the instructions appears to hinge on the limitation that “only” depreciation could be claimed and when the reimbursement issue has a multi-year effect that involves potentially large reimbursement amounts.

⁹⁹ See *Bethesda*, 485 U.S. at 405.

¹⁰⁰ Provider’s CRB at 7.

The Board finds this argument attempts to negate any responsibility of the Provider for the accuracy of the cost reports. As supported by the Provider's certification on Worksheet S of the cost report,¹⁰¹ in conjunction with the provider documentation responsibilities in 42 C.F.R. §§ 413.20 and 413.24,¹⁰² it is not the Medicare Contractor's responsibility to audit the cost report to identify costs that the Provider could potentially have claimed or forgot to claim as highlighted by the nature of the implicit interest that is addressed in the instant cases. Implicit interest differs from *actual* interest because *implicit* interest is not actually paid, and as such, is not reported on the provider's books/financial statements. Thus, a provider must document it by calculating it based on the relevant contract(s) and then add it to the cost report, as appropriate. Nothing in the record suggests that the Provider filed the cost report with any calculation of implicit interest amounts to alert the Medicare Contractor of this potential cost, and, regardless, the Medicare Contractor had nothing "in sufficient detail"¹⁰³ nor "capable of being audited"¹⁰⁴ to support any potential implicit interest.¹⁰⁵

¹⁰¹ The cost report certification from Worksheet S in PRM 15-2, Ch. 36 for the time at issue stated:

"I HEREBY CERTIFY that I have read the above statement and that *I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses* prepared by . . . for the cost reporting period beginning . . . and ending . . . and that to the best of my knowledge and belief, *it is a true, correct and complete statement prepared from the books and records of the provider in accordance with applicable instructions*, except as noted. I further certify that *I am familiar with the laws and regulations regarding the provision of health care services* and that the services identified in this cost report were provided in compliance with such laws and regulations."

(Emphasis added.) The form is available at the end of PRM 15-2, Ch. 36 at: <https://www.cms.gov/regulations-and-guidance/guidance/manuals/paper-based-manuals-items/cms021935>.

¹⁰² In particular, 42 C.F.R. § 413.24(c) addresses the "Adequacy of cost information," stating: "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. Adequate data *capable of being audited* is consistent with good business concepts and effective and efficient management of any organization . . ." (Bold, italics emphasis added).

¹⁰³ 42 C.F.R. § 413.24(c).

¹⁰⁴ *Id.*

¹⁰⁵ Indeed, it does not appear that the Provider maintained *contemporaneous* documentation of the alleged implicit interest notwithstanding its duty, under 42 C.F.R. § 413.20, to do so. In this respect, the Board notes that Exhibit P-26, submitted with the Provider's CRB is simply a spreadsheet of calculations, with no supporting, auditable, third-party documentation. It is *undated*, other than the date provided on which it was submitted to the District Court in 2017, well after the cost reporting periods in question. The Board has no way to ascertain if this was provided to the Medicare Contractor as part of the audits or not. A Calculation of the Estimated Fair Value was also included as Exhibit P-27, and the Provider notes in its Consolidated Responsive Brief that this calculation is "dated December 11, 2008." [Provider's CRB at 10]. This is well after the cost reports in question were filed. At the same time, the Provider refers to the fact that the Medicare Contractor "does not raise any concerns with respect to the calculation of the implicit interest rate as 10.83% by John Beall of Philip's Medical. See Letter from John R. Beall to Shirley Smith, dated December 10, 2003 (Exhibit P-28)." [*Id.*] Again, the Board notes that this lease was entered into in 1994. These three Exhibits suggest that, after the Provider found its error, it began to analyze the situation, determine an implicit interest rate (in 2003), calculate an Estimated Fair Value (in 2008), and develop a carryforward interest schedule (in 2017). Nothing has been provided to support that the provider was aware of the necessity of this interest calculation at the time the cost reports were filed, much less had contemporaneous documentation. 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).

Based on the foregoing, the Board finds that the cost reporting errors and omissions relating to the virtual lease interest expense raised in the appeals were due solely to Memorial City's negligence in understanding and implementing the Medicare regulations and guidance governing the reimbursement of such items on the Medicare cost report. Memorial City presented no evidence to the contrary outside of testimony from one witness, Ms. Savitzky, which the Board determined is uncorroborated and unpersuasive. Accordingly, the Board finds that Memorial City has not met its burdens of proof and production of evidence in 42 C.F.R. § 405.1871(a)(3).

In summary, while the Provider did file a jurisdictionally valid appeals for dissatisfaction with issues other than the capital lease interest issue that gives the Board gateway jurisdiction *over the NPRs at issue* under § 1395oo(a), the Board: (1) finds that the Provider was at fault for the capital lease interest cost not being claimed on its cost reports for the fiscal years at issue and, thus, did not have the right to *directly* appeal the unclaimed capital lease interest issue under § 1395oo(a) (*i.e.*, there is no mandatory jurisdiction over this issue); and (2) declines to exercise its discretion under 42 U.S.C. § 1395oo(d) to hear the capital lease interest issue as it was an unclaimed cost when the reimbursement of those costs was not precluded by a specific law, regulation, CMS Ruling or manual instruction (and again the Provider was at fault for not including the unclaimed cost on the cost reports at issue).¹⁰⁶

DECISION OF BOARD MAJORITY:

The Board concludes that Provider does not have a right to appeal the capital lease interest cost at issue under 42 U.S.C. § 1395oo(a) for fiscal years ("FYs") 1996, 1998, 2000 and 2001 and declines to hear the matter pursuant to its discretionary powers under 42 U.S.C. § 1395oo(a).

Board Members Participating:

Kevin D. Smith, CPA
 Ratina Kelly, CPA
 Shakeba DuBose, Esq. (concurring in part,
 and dissenting in part)

For the Board:

9/29/2026

X Kevin D. Smith, CPA

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

¹⁰⁶ See *supra* note 55. Also, as discussed at *supra* note 54 and accompanying text, the Board reached this question as gateway jurisdiction under 42 U.S.C. § 1395oo(a) had already been established and the Secretary's position on how that occurred has already been explained to the District Court and is not on review on remand.

Board Member Shakeba DuBose, Esq. concurring in part, dissenting in part:

Although I concur with the Board Majority’s finding that Memorial City has not met its burden of proof as to its claim of erroneous guidance from its former Fiscal Intermediary (now known as a Medicare Administrative Contractor or “MAC”) with respect to its unclaimed costs of imputed interest on its virtual purchase lease, and ultimately agree that it is not entitled to reimbursement of the unclaimed costs of the imputed interest because the omission of the interest expense from the cost reports at issue has not been substantiated as a consequence of erroneous guidance from the MAC,¹⁰⁷ I respectfully dissent from the Board Majority’s opinion with respect to its jurisdictional findings as set forth below.

I. Case Law Governing PRRB Jurisdiction Over Unclaimed Costs

As referenced in the Board Majority’s Opinion, the remanding District Court summarized and distinguished certain cases that addressed the *general issue* of whether the Board has jurisdiction over unclaimed costs. To provide additional context, the undersigned extends that discussion:

In *Bethesda Hospital Association v. Bowen*,¹⁰⁸ providers filed their costs reports self-disallowing for the costs of their malpractice insurance premiums.¹⁰⁹ On appeal to the Board, the providers challenged the validity of the 1979 regulation that limited Medicare reimbursement for those malpractice insurance premiums and sought reimbursement under the law prior to the promulgation of the 1979 regulation.¹¹⁰ The Board held that it lacked jurisdiction over the unclaimed costs because they were self-disallowed.¹¹¹ The District Court found the Board’s jurisdictional determination improper, but the Court of Appeals overturned the District Court’s decision.¹¹² Particularly, the Court of Appeals held that the Board’s jurisdictional determination was proper because the providers had self-disallowed the premium costs and had failed to challenge the 1979 regulation before the fiscal intermediary.¹¹³

Granting certiorari, the Supreme Court, held that the plain language of 42 U.S.C. 1395oo(a) provides that the Board’s jurisdiction over a matter is invoked upon a provider’s timely appeal (within 180 days) of a final determination where it is dissatisfied with its total reimbursement (of at least \$10,000) for the covered cost reporting period.¹¹⁴ The Supreme Court went on to hold that once the Board’s jurisdiction under §1395oo(a) is invoked, §1395oo(d) allows the Board:

to review and revise a cost report with respect to matters not contested before the fiscal intermediary. The *only limitation* prescribed by Congress is that the matter must have been “covered

¹⁰⁷ See Tr. 123-124.

¹⁰⁸ 485 U.S. 399 (1988).

¹⁰⁹ *Bethesda* at 399.

¹¹⁰ *Id.*

¹¹¹ *Id.*

¹¹² *Id.*

¹¹³ *Id.* at 402.

¹¹⁴ *Id.* at 403-404.

by such cost report,” *that is*, a cost or expense that was incurred within the period for which the cost report was filed, ***even if such cost or expense was not expressly claimed.***¹¹⁵

Ultimately, the Supreme Court reversed the appellate court’s decision and held that the providers’ self-disallowance of claims that were clearly prohibited by the regulation was proper—distinguishing it from a scenario where providers “fail to request from the intermediary reimbursement for all costs to which they are entitled under applicable rules.”¹¹⁶ The Court also held that no statute or regulation mandated that a challenge to the validity of a regulation must first be presented to a fiscal intermediary as such would be an exercise in futility (where the intermediary is bound by the regulations and must apply them accordingly).¹¹⁷

Following the Supreme Court’s decision in *Bethesda*, over a 13-year period, litigation ensued over the issue of whether the jurisdictional “dissatisfaction” criterion of § 1395oo(a) is met—if a provider’s appeal includes an issue based on unclaimed costs omitted from its cost report. However, it was assessed differently across the Ninth, Seventh, and First Circuits.

In *Adams House Healthcare v. Bowen*,¹¹⁸ the providers followed reimbursement manual rules and instead of claiming certain assets and labor and delivery room patient days in their respective cost reports, the providers only listed the assets in one cost report and only included patient days in a per diem calculation in the other cost report.¹¹⁹ The Board declined to consider the unclaimed costs because they were not expressly disclosed in the cost report for the Medicare Contractor consideration.¹²⁰ Upon review of the Board’s decision, the Ninth Circuit held that the plain language of § 1395oo(a) provides a hearing opportunity for a provider who is dissatisfied with a Medicare Contractor’s final determination and that § 1395oo(d) limits the Board’s review to costs incurred and reflected in cost reports for the relevant fiscal year (i.e., “matters covered by a cost report”), “even if it was not expressly claimed in the cost report.”¹²¹ Disagreeing with the First Circuit’s holding in *St. Luke’s Hosp. v. Secretary of Health & Human Servs.* (a pre-*Bethesda* case) that held that § 1395oo(d) gave the Board discretion to hear appeals or not,¹²² in *Adams House*, the Ninth Circuit held that under § 1395oo(d), “[t]he discretionary language does not describe the Board’s power to accept or reject appeals. It describes the Board’s options once an appeal is filed[]” and that the entitlement to a hearing is provided for in § 1395oo(a).¹²³

Next, in *Little Company of Mary Hospital v. Shalala*,¹²⁴ due to glitches in its DRG software, providers underbilled for certain ICD-9 codes and did not discover the error until long after the DRG assignment correction period has passed.¹²⁵ The Board declined jurisdiction over the appeal because the providers failed to submit any corrections within the prescribed time before

¹¹⁵ *Id.* at 406.

¹¹⁶ *Id.* at 405.

¹¹⁷ *Id.* at 404.

¹¹⁸ See *Adams House Health Care v. Bowen*, 862 F.2d 1371 (1988).

¹¹⁹ *Id.* at 1373.

¹²⁰ *Id.* 1373 – 1374.

¹²¹ *Id.* at 1375.

¹²² *Id.*

¹²³ *Id.*

¹²⁴ *Little Company of Mary Hospital v. Shalala* 24 F.3d 984 (7th Cir. 1994).

¹²⁵ *Id.* at 987.

payment.¹²⁶ The Seventh Circuit stated that the Board’s jurisdiction emanates from 42 U.S.C. § 1395oo(a) and in accordance with *Bethesda*, held that claims for which the provider is entitled to reimbursement under Medicare rules must be first presented to the intermediary to meet the dissatisfaction criterion under § 1395oo(a).¹²⁷ Ultimately, the Seventh Circuit held that 42 U.S.C. § 1395oo(a) only confers jurisdiction over (1) costs claimed on the cost report or (2) “self-disallowed” costs believed to be prohibited by Medicare reimbursement policy; and that costs inadvertently or mistakenly omitted from a cost report were not subject to appellate review.¹²⁸

Opposite the Ninth Circuit’s holding in *Adams House*, in a matter before the First Circuit in *Maine General Medical Center v. Shalala*,¹²⁹ the providers mistakenly claimed zero (\$0) for its bad debts in their respective cost reports.¹³⁰ The Board dismissed the bad debts issue from the appeal for lack of jurisdiction because the appealed bad debt amounts were not matters covered by the cost report.¹³¹ The First Circuit, still relying on a *St. Luke’s* case as good law,¹³² held that interpreting § 1395oo as a whole, “the Board has statutory jurisdiction to hear claims not first raised before the intermediary, but it may [accept or] decline to do so as a matter of discretion[.]” in accordance with an adopted policy, or on a case-by-case basis.¹³³

Later, in *Loma Linda University Medical Center v. Leavitt*,¹³⁴ the provider had incorrectly offset its income and inadvertently zeroed out interest expenses on its cost report and after filing an appeal of its NPR, subsequently added the interest issue.¹³⁵ The Board accepted jurisdiction over the additional issue and found that although the Medicare Contractor had not made a specific interest expense adjustment in its NPR, by accepting the interest income offset with a clear error that it should have corrected, an audit determination had actually been made.¹³⁶ In *Loma Linda*, the Ninth Circuit held:

We conclude that once the Board acquires jurisdiction pursuant to 42 U.S.C. § 1395oo(a) over a dissatisfied provider’s cost report on appeal from the intermediary’s final determination of total reimbursement due for a covered year, it has discretion under § 1395oo(d) to decide whether to order reimbursement of a cost or expense that was incurred within the period for which the cost report was filed, even though that particular expense was not expressly claimed or explicitly considered by the intermediary.¹³⁷

¹²⁶ *Id.* at 989 - 990.

¹²⁷ *See Little Company of Mary Hosp.* at 993.

¹²⁸ *Id.*

¹²⁹ *Maine General Medical Center v. Shalala*, 205 F.3d 493 (1st Cir. 2000).

¹³⁰ *Id.* at 494.

¹³¹ *Id.* at 495.

¹³² *See St. Luke’s Hosp. v. Secretary of Health & Human Servs.*, 810 F.2d 325, 327–28 (1st Cir.1987).

¹³³ *Maine General* at 499 - 501.

¹³⁴ *Loma Linda University Medical Center v. Leavitt*, 492 F.3d 1065, 1068, 1071 (9th Cir. 2007)

¹³⁵ *Id.* at 1069.

¹³⁶ *Id.*

¹³⁷ *Id.* at 1068.

In 2015, the Secretary found support for its position that the Board does not have jurisdiction over costs omitted from the cost report in the D.C. District Court’s decision in *Saint Vincent Indianapolis Hosp. v. Sebelius*.¹³⁸ In *Saint Vincent*, under *Chevron*,¹³⁹ the court analyzed the Secretary’s interpretation of “dissatisfaction” under 42 U.S.C. 1395oo(a), where the provider failed to claim costs on its cost report and appealed to the Board, which declined jurisdiction over the matter because it attributed the omission to the provider’s own negligence in misunderstanding cost reimbursement regulations.¹⁴⁰ The district court specifically acknowledged that the Board’s decision was premised upon the provider’s error or omission—“rather than the FI’s/MAC’s action.”¹⁴¹ The district court ultimately upheld the Board’s jurisdictional determination finding that it was based upon a “permissible construction of the statute.”¹⁴²

II. The Board’s Historical and Current Position on its Jurisdiction Over Unclaimed Costs

The Board’s historical interpretation of 42 U.S.C. §§ 1395oo(a) and (d) and their reliance upon the First Circuit’s decision in *Maine General* (and by extension, *St. Luke’s*) along with the D.C. District Court’s decision in *St. Vincent*, has previously brought the Board to the legal conclusion that:

Only when the provider has established jurisdiction under § 1395oo(a) ***with respect to one or more such claims/issues*** can the Board ***then exercise discretion*** [under § 1395oo(d)] ***to hear other claims not considered by the intermediary*** (e.g., unclaimed costs). While the provider did file a jurisdictionally valid appeal for dissatisfaction ***with issues other than the capital lease interest issue that gives the Board jurisdiction under subsection (a)***, the Board Majority declines to exercise discretion under 42 U.S.C. § 1395oo(d) to hear the appeal of the unclaimed costs of capital lease interest when reimbursement of those costs was not precluded by a specific law, regulation, CMS Ruling or manual instruction.¹⁴³

Notably, in acknowledging the circuit court split on the issue, the Board Majority now opines that “it is apparent that decisions of the U.S. Court of Appeals for the D.C. Circuit and the 5th Circuit are binding for purposes of the Board’s analysis of jurisdiction as administrative agencies follow the law of the circuit whose courts have jurisdiction over the cause of action.”¹⁴⁴ The Board

¹³⁸ 134 F. Supp. 3d 238 (D.D.C. 2015).

¹³⁹ *Chevron, U.S.A., Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837 (1984), **overruled by** *Loper Bright Enters. v. Raimondo*, 603 U.S. 369 (2024).

¹⁴⁰ See *Saint Vincent* at 240-241.

¹⁴¹ *Id.* at 241. See also *Little Co. of Mary Hosp.* at 992 (where the Seventh Circuit stated, “On this view, the Board’s review on appeal from an NPR is limited to those acts of the intermediary that are first reflected in the NPR. For example, if the intermediary committed an error in reconciling the periodic payments, such an error would be cognizable by the Board on reviewing the NPR.”)

¹⁴² *Id.* at 243.

¹⁴³ See Board Majority’s jurisdictional findings in the instant matter pre-remand, *supra*; see also Ex. P-5 Board Decision, PRRB Case Nos.: 01-2533, 01-2535, and 03-1411 at 9 - 10 (Sept. 12, 2014); Ex. P-6 Board Decision, PRRB Case No.: 04-2243 at 3-4 (Nov. 15, 2017).

¹⁴⁴ See pg. 9 and accompanying Fn. 34, *supra*.

Majority goes on to cite the “unpublished 2025 decision” in *University of Chicago Medical Center v. Kennedy*. Here, it is important to note that while the Board points out that the CMS Administrator “applies as ***controlling precedent*** the law of the Circuit in which the Provider is located...[and] the law of the D.C. Circuit[.]”¹⁴⁵ neither is cited by the Board Majority in this case. The Board Majority cites no Fifth Circuit case on the issue and the D.C. Circuit Court’s Rule 36(e)(2) states: “While unpublished dispositions may be cited to the court in accordance with FRAP 32.1 and Circuit Rule 32.1(b)(1), ***a panel’s decision to issue an unpublished disposition means that the panel sees no precedential value in that disposition.***”¹⁴⁶

Now, based upon its reliance on the holding in *UChicago* and its continued reliance on the cases cited therein (*Loma Linda*, *Maine General*, and *St. Luke’s*), in the instant matter, the Board Majority comes to the legal conclusion that:

In the instant cases, Memorial City failed to claim the implicit interest it now seeks. It is clear in the instant cases that gateway jurisdiction under 42 U.S.C. § 1395(a) has been established over the NPR at issue in each of these cases because the Provider did file a jurisdictionally valid appeal for dissatisfaction **with issues other than the capital lease interest issue.** Given that gateway jurisdiction over the NPRs at issue has been established, it is moot to revisit the legal question of: (1) whether “dissatisfaction” under 42 U.S.C. § 1395oo(a) applies only to the total amount of program reimbursement reflected on the NPR; or (2) in the alternative, whether “dissatisfaction” needs to be tied to a specific gateway claim in these cases because it is clear that Memorial City’s appeal request for each of the fiscal years at issue **did include other issues which the Medicare Contractor did consider.** As a result, ***for purposes of this decision***, the Board need not revisit that legal issue because, under either approach, gateway jurisdiction under § 1395(a) has been established and because the Secretary’s position on this point has been made clear to the District Court.[□] Further, once that gateway jurisdiction has been established, courts have generally upheld the Board’s position that it has discretion (*i.e.*, is not required) under § 1395oo(d) as to whether it will hear unclaimed costs not raised before and considered by the Medicare Contractor.¹⁴⁷

Contrarily, the Board Majority goes on to state:

[T]he Board Majority: (1) finds that the Provider was at fault for the capital lease interest cost not being claimed on its cost reports for the fiscal years at issue and, thus, did not have the right to *directly* appeal the unclaimed capital lease interest issue under § 1395oo(a)

¹⁴⁵ *Id.* Emphasis added.

¹⁴⁶ Emphasis added.

¹⁴⁷ Bold and underline emphasis added.

(i.e., there is no mandatory jurisdiction over this issue); and (2) declines to exercise its discretion under 42 U.S.C. § 1395oo(d) to hear the appeal of the unclaimed costs of capital lease interest when reimbursement of those costs was ***not*** precluded by a specific law, regulation, CMS Ruling or manual instruction (and again when the fault for the costs not being claimed lies with the Provider).¹⁴⁸

Preclusion of Appeal Rights

In either the Board's historical stance¹⁴⁹ or this latest iteration, with regards to the Board's jurisdiction over unclaimed costs, a provider's right to appeal unclaimed costs was and still is ***limited*** to instances where it ***first appeals other unrelated*** claimed costs or self-disallowed costs on its cost report to establish jurisdiction under § 1395oo(a)—as opposed to related matters ***covered by the cost report***. Thus, the Board Majority's legal conclusion that appeals of unclaimed costs are restricted to instances where they are dependent upon appeals of other unrelated claimed costs or self-disallowed costs—***unequivocally cuts off a provider's right to appeal*** where a provider ***may only be*** dissatisfied with an unclaimed cost even where related costs are covered on its cost report but are not at issue in an appeal. This application of the Board's jurisdiction should not be used to preclude a provider's statutory right to appeal unclaimed costs where it has filed a timely appeal and met the amount in controversy ***and*** provides a sound rationale as to its dissatisfaction (e.g., alleged detrimental reliance on a MAC's erroneous guidance) with its final determination of its ***total reimbursement—for a matter covered by its cost report***, which invokes the Board's jurisdiction under § 1395oo(a).¹⁵⁰

III. The Board has jurisdiction over the unclaimed costs and has already exercised jurisdiction over the issue.

Generally, and particularly, where it relates to an allegation of detrimental reliance upon the MAC's guidance, the undersigned finds more sound, the interpretation of 42 U.S.C. §§ 1395oo(a) and (d) espoused in the Ninth Circuit's *Adams House Health Care v. Bowen*,¹⁵¹ which clarified the discretionary jurisdiction analysis in *St. Luke's* (a pre-Bethesda First Circuit decision) and held that the Board is obligated to hear appeals of matters covered in a cost report (which may be standalone appeals of unclaimed costs ***if covered in the cost report and properly appealed***), stating:¹⁵²

¹⁴⁸ See p. 19, *supra*.

¹⁴⁹ See e.g., Board Majority's jurisdictional findings in the instant matter pre-remand, *supra*; see also Ex. P-5 Board Decision, PRRB Case Nos.: 01-2533, 01-2535, and 03-1411 at 9 - 10 (Sept. 12, 2014); Ex. P-6 Board Decision, PRRB Case No.: 04-2243 at 3-4 (Nov. 15, 2017).

¹⁵⁰ Recall that in *Bethesda*, the Supreme Court held that: "The ***only limitation*** [upon the Board's jurisdiction] prescribed by Congress is that the matter must have been ***"covered by such cost report," that is, a cost or expense that was incurred within the period for which the cost report was filed, even if such cost or expense was not expressly claimed.***" *Id.* at 406. Emphasis added.

¹⁵¹ *Adams House Health Care v. Bowen*, 862 F.2d 1371 (1988).

¹⁵² See also *Loma Linda* at 1072 -1073 (where the Ninth Circuit, citing *Adams House*, states, "What we did there was explain that the discretionary language in *St. Luke's* does not describe the Board's power to accept or reject appeals; rather, "[i]t describes the Board's options once an appeal is filed." 862 F.2d at 1375.).

One question remains: *must* the Board consider all matters timely raised before it? The First Circuit held that the Board had discretion to hear appeals or not, relying on language in 42 U.S.C. § 1395oo (d) providing that the Board “shall have the power” to do certain things. *See St. Luke's Hosp. v. Secretary of Health & Human Servs.*, 810 F.2d 325, 327–28 (1st Cir.1987). ***We disagree. The discretionary language does not describe the Board's power to accept or reject appeals. It describes the Board's options once an appeal is filed.*** More fully quoted, section (d) provides that the Board “shall have the power to affirm, modify, or reverse a final determination ... and to make any other revisions.” ***The Board has no discretion to reject an appeal***, for as 42 U.S.C. § 1395oo (a) provides,

Any provider of services which has filed a required cost report within the time specified in regulations *may obtain a hearing* with respect to such cost report by a Provider Reimbursement Review Board....
(emphasis added)

The word “may” in the emphasized language connotes not contingency but entitlement. *Cf. Goodman v. City Products Corp.*, 425 F.2d 702, 703 (6th Cir.1970) (The phrase “a civil action may ... be brought” refers to “the option of the aggrieved party to bring a lawsuit, not to a discretion in the Court.”).¹⁵³

Thus, in accordance with the *Adams House* holding and rationale that § 1395oo(d) ***does not*** convey that the Board may reject an appeal (or appeal of an issue) that is timely raised and meets the amount in controversy, the Board would have jurisdiction over a provider's *unclaimed costs threshold issue as raised*.¹⁵⁴ Here, it is important to note that a provider's unclaimed costs threshold issue is still subject to all procedural and substantive requirements in order for the costs to ultimately be deemed reimbursable. In the instant matter, Memorial City's threshold issue alleges that it failed to claim the interest costs on its cost reports for the relevant fiscal years because it relied on erroneous guidance from the MAC. Thus, the Provider is dissatisfied with its total reimbursement.¹⁵⁵

¹⁵³ *Id.* at 1375 – 1376 (bold italics emphasis added).

¹⁵⁴ Herein, the undersigned uses the phrase “unclaimed costs threshold issue” as it relates to presented *factual* issues that must be resolved for the Board to determine its legal authority and/or for the Board to determine whether the appeal will move forward for substantive consideration.

¹⁵⁵ *See Saint Vincent* at 241. Here, acknowledging *Saint Vincent's* distinction in the source of the error, logically, if the plaintiff failed to meet dissatisfaction criterion because the omission stemmed from its own negligence, then it follows that if the errors are alleged to stem from erroneous guidance provided by a MAC, then dissatisfaction exists upon appeal; *however*, subsequently, if the allegations are not substantiated by provider, then their appeal of the unclaimed costs fails—but they have been allowed to exercise their appeal rights and been heard by the Board on their unclaimed costs threshold issue of MAC error.

This view of the Board's jurisdiction is also supported by the remanding court's analysis and holding:

Courts have not directly addressed the question of whether § 1395oo(a) requires mandatory jurisdiction whenever a provider makes a mistake on a cost report due to erroneous guidance from a MAC. However, all of the cases in which the Board had the authority to decline to exercise jurisdiction concerned situations in which omissions or mistakes in cost reports were attributed to a provider's own negligence. *See, e.g., Little Company of Mary Hospital v. Shalala*, 24 F.3d 984, 993 (7th Cir. 1994). In *Saint Vincent Indianapolis Hospital*, the district court differentiated these scenarios from those in which the MAC is at fault. 134 F. Supp. 3d 238, 241 (D.D.C. 2015). The court explained that a provider could not be "dissatisfied" within the meaning of § 1395oo(a) where errors and omissions on a cost report stem from the provider's "own negligence in understanding the Medicare regulations governing the reimbursement of such costs *rather than the FI/MAC's action.*" *Id.* (emphasis added).

Based on the plain language of the statute, a provider who receives false information from its MAC would likely be "dissatisfied" with the "final determination of the organization serving as its fiscal intermediary." *See* 42 U.S.C. § 1395oo(a)(1). In *Bethesda Hospital*, the Supreme Court explained that "defaults [and omissions] might well establish that a provider was satisfied with the amounts requested in its cost report and awarded by the fiscal intermediary." 485 U.S. at 405. If the intermediary itself is at fault, however, then any reasonable provider would be "dissatisfied" with the intermediary. ***If the intermediary provides erroneous guidance to a provider that adversely affects its reimbursement, then the provider's only recourse is to appeal to the Board.*** Section 1395oo establishes a mechanism for the Board to review any actions and omissions made by the intermediary, "even though such matters were not considered by the intermediary in making such final determination." *See* 42 U.S.C. § 1395oo(d). ***Thus, a provider who is "dissatisfied" with the actions taken by the intermediary and the "amount of total program reimbursement" has a right to a hearing before the Board.***¹⁵⁶

Here, the undersigned's interpretation of the remanding court's foregoing holding also differs from that of the Board Majority, which interprets the aforementioned as the remanding District Court's explanation of the potential novelty of a jurisdictional issue where erroneous guidance of the MAC is alleged, and "how it would apply 42 U.S.C. § 1395oo(a) if the Board were to find that Memorial City is not at fault for the capital lease interest cost not being claimed on the cost reports at issue

¹⁵⁶ Provider's Exhibit P-7 (S.D. Tex., Aug. 28, 2018 Remand Order) at 14-15 (emphasis added).

and that the fault lies instead with the Medicare Contractor[.]” To support its interpretation, the Board Majority focuses on the second sentence in the quote above but does not acknowledge that it relates back to the first sentence: the District Court first states that the question of whether mandatory jurisdiction is invoked in situations where a provider’s error or omission stems from reliance on erroneous MAC guidance—has yet to be addressed by the courts. Then, the District Court acknowledges that all of the *prior* cases where the Board declined to exercise jurisdiction were cases—absent any allegation or finding of MAC erroneous guidance. This is supported by the Court’s next statements regarding the distinction drawn in *Saint Vincent*.

Additionally, the remanding District Court implicated the Board’s jurisdiction over the matter as it related to its fact-finding. When addressing the Secretary’s position that there was no dispute over a material fact, the remanding court stated, “‘A fact is ‘material’ if its resolution in favor of one party might affect the outcome of the lawsuit under governing law. [citation omitted]. Plaintiff’s allegation that the MAC caused the omission on its cost report is only material if it entitles Plaintiff to a hearing under § 1395oo(a).”¹⁵⁷ Based on the aforementioned, Ultimately, the remanding court stated:

Because the Board’s decisions were not supported by substantial evidence, they must be set aside. [citation omitted]. And because the question of whether the Plaintiff or MAC caused the omissions on Plaintiff’s cost reports is a genuine issue of material fact, the case must be remanded to the Board for further proceedings.¹⁵⁸

Thus, under the Ninth Circuit’s holdings in *Adams House* and in *Loma Linda*,¹⁵⁹ and the remanding district court analysis,¹⁶⁰ the Board has jurisdiction over unclaimed cost appeals (including an independent unclaimed costs issue)—where a provider has timely appealed and met the amount in controversy alleging a sound basis of its dissatisfaction with its total reimbursement (such as its detrimental reliance on bad advice from the MAC (i.e., threshold issue)), *and* where its unclaimed costs are indeed covered by the cost report subject of the appeal.

¹⁵⁷ *Id.* at 14.

¹⁵⁸ *Id.* at 15.

¹⁵⁹ *See Loma Linda* at 1073:

What we did [in *Adams House*] was explain that the discretionary language in *St. Luke’s* does not describe the Board’s power to accept or reject appeals; rather, “[i]t describes the Board’s options once an appeal is filed.” 862 F.2d at 1375. We are guided by this construct here in holding that once jurisdiction has been obtained over a cost report because of a provider’s dissatisfaction with the intermediary’s final determination of the total reimbursable amount due, the Board *then* has discretion to consider evidence that was not before the intermediary; to affirm, modify or reverse the final determination; and to revise matters covered in the cost report that the intermediary did not consider.

Emphasis added.

¹⁶⁰ *See* Provider’s Exhibit P-7 (S.D. Tex, Aug. 28, 2018 Remand Order) at 11 – 12 (where the remanding district court analyzed the holdings in *Maine General* and *Loma Linda* stating: “Thus, both the First and Ninth Circuits held that the Board has [general] jurisdiction over claims not included in the initial cost report, even if they were inadvertently or negligently omitted. *Maine General Med. Ctr.*, 205 F.3d at 497; *Loma Linda Univ. Med. Ctr.*, 492 F.3d at 1068.); *see id.* at 14-15.

Two-Step Analysis

Accordingly, through due course of the appeal proceedings, before the Board reaches the question of whether such unclaimed costs are reimbursable, the Board should engage in a two-step analysis to: 1) determine whether a provider's unclaimed costs threshold issue is substantiated by a preponderance of reliable and substantial evidence in the record;¹⁶¹ and 2) determine whether the unclaimed costs are covered by the cost report at issue—that is, were the costs incurred within the cost report fiscal year and “reflected in that report, even if [they were] not expressly claimed.”¹⁶²

Here, where the Board Majority acknowledges that issues other than the virtual purchase lease interest issue has invoked the Board's jurisdiction, or even assuming *arguendo* there were no other appealed issues and the provider was pursuing the unclaimed interests costs related to a cost covered on the cost report, if the Board finds that the omission was the fault of the MAC's erroneous guidance and that the unclaimed costs are covered by the cost report(s) at issue, the Board could either conduct a *de novo* review of the unclaimed costs to determine reimbursable amount or it could remand the issue to the MAC.¹⁶³ On the other hand, if the Board finds that the fault lies with the provider rather than the MAC, but that the costs are reflected in the cost report, then under § 1395oo(d), the Board *may, but is not required to*, review the unclaimed costs *de novo* and determine the reimbursable amount¹⁶⁴ or remand to the MAC for reimbursement determination. ***However***, even after taking a timely filed unclaimed costs issue that meets the amount in controversy (standalone or combined with other appealed issues) under its jurisdiction based on a factual threshold allegation of MAC error and ultimately finding that allegation unsubstantiated, ***nothing in the applicable law mandates that Board rule in favor of a provider that failed to make a claim for costs to which it was entitled under the law or failed to self-disallow costs where claiming such costs would have been futile, particularly where the fault for the omission rests with the provider and not the MAC.***¹⁶⁵ ***The Board's jurisdiction over a matter is not synonymous with granting an appellant relief to which is not entitled due to its own failure to meet specific procedural and/or substantive requirements.*** Finally, if the Board finds that the omission of the costs was the provider's fault¹⁶⁶ and that the costs are not covered or reflected in the cost report,¹⁶⁷ the Board must find that the costs are not reimbursable.¹⁶⁸ Here, it

¹⁶¹ Provider's Exhibit P-7 (S.D. Tex., Aug. 28, 2018 Remand Order) at 14-15 (emphasis added).

¹⁶² *Adams House*. at 1375; see also *Bethesda* at 406.

¹⁶³ Note that here, the Board would already be operating under its 1395oo(a) mandatory jurisdiction in accepting that the dissatisfaction requirement was met upon the provider's pleading its belief that it received erroneous guidance for the unclaimed costs.

¹⁶⁴ See *Bethesda* at 406 (where the Court held that the language in 1395oo(d) *does not* mandate, but “***allows*** the Board once it obtains jurisdiction pursuant to subsection (a), to review and revise a cost report with respect to matters not contested before the fiscal intermediary [.]” and that the “the only limitation” prescribed by Congress is that the matter must be covered by the cost report at issue.).

¹⁶⁵ See *Bethesda* at 404 - 405;

¹⁶⁶ See, e.g., *Little Company of Mary Hospital* at 993.

¹⁶⁷ See *Bethesda* at 406; see also *Adams House* at 1375.

¹⁶⁸ See *Saint Vincent* at 241. Here, acknowledging *Saint Vincent's* distinction in the source of the error, logically, if the plaintiff failed to meet dissatisfaction criterion because the omission stemmed from its own negligence, then it follows that if the errors are alleged to stem from erroneous guidance provided by a MAC, then dissatisfaction exists upon appeal; *however*, subsequently, if the allegations are not substantiated by provider, then their appeal of the unclaimed costs fails—but they have been allowed to exercise their appeal rights and been heard by the Board on their unclaimed costs threshold issue of MAC error.

is important to note that although the Board Majority finds that it does not have mandatory jurisdiction over the matter and that it will not exercise its discretion to review the matter, it undertook the steps outlined above in its fact-finding, which is not separate from jurisdiction; however it is a method by which a tribunal exercises its jurisdiction.

As previously mentioned, the undersigned agrees with the Board Majority's determination that Memorial City's assertion that its unclaimed interest expense was caused by reliance on erroneous MAC guidance is unsubstantiated by the evidence presented. However, the undersigned does find that the matter was covered by the respective cost reports. Specifically, Memorial City reported and claimed \$26.1 million in virtual purchase/capital lease payments on Worksheet A, which were offset on Worksheet A-8 and included an adjustment for depreciation costs.¹⁶⁹ However, Memorial did not include allowable imputed or implicit interest in the costs of ownership adjustment on Worksheet A.¹⁷⁰ Upon auditing the relevant fiscal year cost reports, the MAC adjusted the capital costs.¹⁷¹

Based on the foregoing, the undersigned finds that although the Board has jurisdiction over the unclaimed costs issue—since Memorial City claimed its lease payments related to the virtual purchase and the MAC adjusted the capital costs tied to that purchase—the implicit interest is not reimbursable because it was not claimed, despite explicit regulatory language and guidance clearly indicating that interest is included in the costs of ownership, and despite including maintenance, insurance, and taxes as costs of ownership.

Additionally, the undersigned finds that the Board is not obligated to accept all of the parties' Stipulations.¹⁷² Particularly by Stipulation ¶ 16, the parties agreed that if the Board finds that it has jurisdiction over the unclaimed costs issue, that CMS should determine the amount of reimbursement as stipulated by the parties in Stipulation ¶ 15. However, as stated above, the Board's jurisdiction over a matter is not synonymous with a *de jure* finding of reimbursement in favor of the provider. If CMS is inclined to settle the matter in accordance with the parties' stipulations, the parties should engage in the appropriate process to do so; however, such settlement or administrative resolution processes are outside of the Board's purview.

Conclusion

Under the rationales set forth in *Adams House* and *Loma Linda*, § 139500(a) is the jurisdictional gateway to a Board hearing when a provider meets the preliminary jurisdictional requirements (amount in controversy and timeliness of appeal) and the provider asserts dissatisfaction with its total reimbursement determination, which may include a threshold issue that must be resolved to determine whether the unclaimed costs are reimbursable. And, once the Board's general jurisdiction is invoked, then under § 139500(d) the Board may, but is not required to, deem an unclaimed cost reimbursable *after* assessing the threshold issue raised as to why the costs were

¹⁶⁹ See Joint Stipulation ¶ 4.

¹⁷⁰ *Id.* at ¶¶ 5, 13.

¹⁷¹ *Id.* at ¶ 6.

¹⁷² See e.g., *In the case of: Coosa Valley Medical Center v. Bluecross Blueshield Association/Cahaba Government Benefits Administrators, LLC Intermediary*, 2011 WL 2604375 (Jan. 20, 2011) (a review of PRRB Decision No. 2011-D11).

unclaimed on the provider's cost report and whether the costs were indeed covered by the cost report—and whether all other applicable requirements are met. Moreover, the Board's jurisdiction over an unclaimed costs issue should not be premised upon simultaneous or companion appeals of unrelated claims or self-disallowed issues on a cost report ***but upon matters covered by the cost report even if they were not expressly claimed.***

For the foregoing reasons, the undersigned concurs in part and dissents in part with the Board Majority's rationale as to its jurisdiction over Memorial City's unclaimed costs issue.

Concurring in part, dissenting in part:

9/29/2026

X Shakeba DuBose

Shakeba DuBose, Esq.

Board Member

Signed by: SHAKEBA DUBOSE -A