CENTERS FOR MEDICARE AND MEDICAID SERVICES

Decision of the Administrator

In the case of:	**Claim for:**
University of Chicago Hospitals & Clinics **Provider** **vs.** **Blue Cross/ Blue Shield Association/** **Federal Blue Cross & Blue Shield/** **National Government Services-Illinois** **Intermediary**	**Provider Cost Reimbursement Determination for Cost Reporting Period Ending: 06/30/96** **Review of:** **PRRB Dec. No. 2007-D57** **Dated: August 8, 2007**

This case is before the Administrator, Centers for Medicare & Medicaid Services (CMS), for review of the decision of the Provider Reimbursement Review Board (Board). The review is during the 60-day period in §1878(f) (1) of the Social Security Act (Act), as amended (42 USC 1395oo(f)). CMS' Center for Medicare Management (CMM) commented, requesting reversal of the Board's decision. The parties were then notified of the Administrator's intention to review the Board's decision. Subsequently, comments were received from the Provider requesting affirmation of the Board's decision. Accordingly, this case is now before the Administrator for final agency review.

ISSUE AND BOARD'S DECISION

The issue is whether the time spent by residents conducting research in the Provider's facility as part of an approved residency program should be included in the Indirect Medical Education (IME) full-time equivalent (FTE) calculation.

The Board held that the Intermediary's adjustment excluding research time from the FTE resident count used to calculate the Provider's adjustment for IME was improper. The Board found that the regulation did not exclude research time from the IME resident count, nor did it require resident time to be related to patient care. The Board determined that the regulation allowed research time spent by residents to be included in the IME calculation if the residents were enrolled in an approved

teaching program and were assigned to either the area of the hospital subject to the inpatient prospective payment system (IPPS) or the hospital's outpatient department. Thus, since the residents at issue were enrolled in an approved graduate medical education (GME) program and they worked in either the portion of the Provider's facility subject to IPPS, or an outpatient area, the Intermediary's adjustments were improper. The Board also referred to case law in support of its decision.

SUMMARY OF COMMENTS

CMM commented, requesting reversal of the Board's decision. CMM argued that time spent by residents engaged in research not related to patient care cannot be included in the FTE count for IME purposes. CMM noted that the regulation must be read in conjunction with other regulations, which shows that Medicare never pays for non-patient care activity. In addition, a plain reading of the regulation requires that a resident be "assigned to" either the inpatient PPS or outpatient areas of the hospital in order to be counted. CMM noted that, contrary to the Board's finding, the August 1, 2001 Federal Register is a clarification of longstanding policy, and argued that historically CMS has not recognized research time which was not related to patient care. CMM pointed out that the IME adjustment is an add-on to the per-case payment and is based on the standardized amount and the relevant weight of the DRG, which recognize that teaching hospitals have higher allowable costs. The Provider Reimbursement Manual, prohibiting the counting of residents engaged in exclusively research has been in place since 1988.

Further, CMM maintained that the regulation at 42 C.F.R. §412.105(f)(1)(iii)(B), that was added in 2001, did not constitute a new regulation, rather, it merely codified existing policy. In passing the IPPS legislation, the House Committee on Ways and Means acknowledged the link between higher patient costs of medical education and teaching hospitals. Although general acute care hospitals are no longer paid explicitly based on reasonable costs, the IPPS and the IME adjustments are founded on hospital's reasonable operating costs for furnishing patient care. Thus, there is a clear and compelling reason to limit the FTE resident time counted for purposes of IME payment to include only time spent by residents in the diagnosis and the treatment of particular patients. CMM also noted in this case that the Provider failed to document that the research in question was performed in the part of the hospital that is paid under the IPPS or the outpatient department.

The Provider commented, requesting affirmation of the Board's decision. The Provider argued that the Board's decision was consistent with the favorable decisions by the Federal district courts. Citing to case law, the Provider maintained that all courts that have reviewed this issue have determined the CMS' interpretation of Medicare policy is incorrect and that research time spent by residents should be included in a provider's IME FTE count. The Provider noted that the Intermediary entered into stipulation that the only issue preventing payment

of the excluded IME FTE is whether the research time can be included. The applicable requirements for the inclusion of the IME FTEs include the assignment of residents to areas of the hospital subject to the impatient prospective payment system or to the outpatient department. The Provider contended that the inclusion of resident time in the GME FTE count that is also based on reasonable cost principles and that CMS explicitly stated resident research time conducted in the hospital complex is includable in a GME FTE count. The statute only imposes a direct patient care requirement on resident time spent in non-provider settings and, therefore, absence a similar limitation on time spent in other settings implies that all activities including research that are conducted as part of the resident's approved training programs is to be counted.

DISCUSSION

The entire record, which was furnished by the Board, has been examined, including all correspondence, position papers, and exhibits. The Administrator has reviewed the Board's decision. All comments received timely are included in the record and have been considered.

Prior to 1983, under Title XVIII of the Social Security Act, Medicare reimbursed providers on a reasonable cost basis for Part A --Hospital Insurance Benefits. Section 1861(v)(l)(a) of the Act defines "reasonable cost" as "the cost actually incurred, excluding there from any part of the incurred cost found to be unnecessary in the efficient delivery of needed health services, and shall be determined in accordance with regulations establishing the method or methods to be used, and the items to be included...." Section 1861(v)(1)(a) of the Act does not specifically address the determination of reasonable cost, but authorizes the Secretary to prescribe methods for determining reasonable cost, which are found in regulations, manuals, guidelines, and letters.

The Secretary promulgated regulations which explained the principle that reimbursement to providers must be based on the reasonable cost of services covered under Medicare and related to the care of beneficiaries.[1] Reasonable cost includes all necessary and proper cost incurred in furnishing the services in the setting for which payment is authorized under Part A. Necessary and proper costs are costs, which are appropriate and helpful in developing and maintaining the operation of patient care facilities and activities. Accordingly, if a provider's costs include amounts not related to patient care, or costs that are specifically not reimbursable under the Part A program; those costs will not be paid by the Medicare program.

[1] See e.g. 42 C.F.R. §413.9.

Under reasonable cost, the allowable costs of educational activities included trainee stipends, compensation of teachers and other direct and indirect costs of the activities as determined under Medicare cost finding principles. The Secretary promulgated the regulation at 42 C.F.R. §413.85 which permits reimbursement for the costs of "approved educational activities."[2] This regulation defines approved educational activities as "formally organized or planned programs of study usually engaged in by providers in order to enhance the quality of patient care in an institution. The regulations governing research cost, under the "reasonable cost" system of reimbursement were found at 42 C.F.R. §405.422 et. seq. and stated that the "[c]osts incurred for research purposes over and above usual patient care, are not includible as allowable costs."[3] The regulation at 42 C.F.R. §405.422(b)(2) further stated that:

> Where research is conducted in conjunction with and as a part of the care of patients, the costs of usual patient care are allowable to the extent that such costs are not met by funds provided for the research....[4]

Consistent with the regulation, section 500 of the Provider Reimbursement Manual explains that "costs incurred for research purposes, over and above usual patient care, are not includable as allowable costs."[5] Further, section 502 of the PRM provides the following definitions:

> Research. —Research in the context of this principle means a systematic, intensive study directed toward a better scientific knowledge of the science and art of diagnosing, treating, curing and preventing mental or physical disease, injury, or deformity; relieving pain; and improving or preserving health. Research may be conducted at a laboratory bench without the use of patients or it may

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[2] 42 C.F.R. §413.85(b) (1998) further redesignated at 42 C.F.R. §413.90 (2007). This language has been in effect since the beginning of the Medicare program although it was formerly designated 42 C.F.R. §405.421 (1977) and 20 C.F.R. §405.421 (1967).

[3] See 31 Fed. Reg. 14814 (Nov. 22, 1966). *See* 42 C.F.R. §405.422, re-designated 42 C.F.R. §413.5(c)(2), and now at 42 C.F.R. 412.90).

[4] Id.

[5] The Administrator notes that not only are pure research costs not related to patient care, but reimbursement of these costs may in certain circumstances violate the anti-redistribution and community support provisions under the GME provisions. In addition, where research costs include usual patient care costs in conjunction with research, a provider is required to offset costs incurred for usual patient care with applicable research funds. See section 505.1 of the PRM.

> involve patients. Furthermore, there may be research projects that involve both laboratory bench research and patient care research.
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> Usual Patient Care. —Usual patient care is the care which is medically reasonable, necessary, and ordinarily furnished (absent any research programs) in the treatment of patients by providers under the supervision of physicians as indicated by the medical condition of the patients. Also, this definition intends that the appropriate level of care criteria must be met for the costs of this care to be reimbursable. Such care is represented by items and services (routine and ancillary) which may be diagnostic, therapeutic, rehabilitative, medical, psychiatric, skilled nursing, and other related professional health services.
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> Extraordinary Patient Care. —In the context of this principle, extraordinary patient care is the care rendered to research patients which is not medically reasonable, necessary, or ordinarily furnished to patients by providers. Such care is represented by additional patient care days and additional ancillary charges identified as non-Medicare in the patient care costs centers.

Thus, historically under reasonable cost methodology, costs for research purposes not related to patient care were not allowable.

Section 223 of the Social Security Act of 1972 amended section 1861(v)(1)(A) to authorize the Secretary to set prospective limits on the cost reimbursement by Medicare.[6] These limits are referred to as the "223 limits" or "routine cost limits" (RCL), and were based on the costs necessary in the efficient delivery of services. Beginning in 1974, the Secretary published routine cost limits in the Federal Register. These "routine cost limits" initially covered only inpatient general routine operating costs.

In 1982, in an effort to further curb hospital cost increases and encourage greater efficiency, Congress established broader cost limits than those authorized under section 1861(v)(1)(A), the existing routine cost limits. The Tax Equity and Fiscal Responsibility Act (TEFRA) added section 1886(a) to the Act, which expanded the existing cost limits to include ancillary services, operating costs and special care unit operating costs in addition to routine operating costs. Pursuant to section 1886(1)(a)(ii) of the Act, these expanded cost limits, referred to as the "inpatient operating cost limits," applied to cost reporting periods beginning after October 1, 1982. The costs related to approved medical education were not subject to the routine costs limits.

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[6] Pub. Law 92-603.

Under the routine cost limits, and pursuant to §1886(a)(2) of the Act, Medicare also paid for the increased indirect costs associated with a hospital's approved graduate medical education program through an indirect teaching adjustment.[7] Thus, since its inception Medicare has recognized the increased operating costs related to a provider's approved graduate medical education programs through an indirect teaching adjustment.[8]

In 1983, §1886(d) of the Act was added to establish the inpatient prospective payment system (IPPS) for reimbursement of inpatient hospital services furnished to Medicare beneficiaries.[9] Under IPPS, providers are reimbursed their inpatient operating costs based on prospectively determined national and regional rates for each patient discharge, rather than on the basis of reasonable operating costs. However, the bases for the development of these prospective rates continued to be the reasonable operating costs related to the care of hospital inpatients. Under §§ 1886(a)(4) and (d)(1)(A) of the Act, the costs of approved medical education activities were specifically excluded from the definition of "inpatient operating costs" and, thus, were not included in the IPPS hospital-specific, regional, or national payment rates or in the target amount for hospitals not subject to IPPS.[10] Instead, payment for approved medical education activities costs were separately

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[7] Section 1886(a)(2) states that the Secretary shall provide "for such ... adjustments to, the limitation ... as he deems necessary to take into account — (A).... Medical and paramedical education costs...."

[8] 45 Fed. Reg. 21584 (April 1, 1980) (indirect teaching adjustment under pre-TEFRA cost limits); 46 Fed. Reg. 33637 (June 30, 1981)("We included this adjustment to account for *increased routine operating costs* that are generated by approved internship and residency programs, but are not allocated to the interns and residents (in approved programs) or nursing school cost centers on the hospital's Medicare cost report. Such costs might include, for example, increased medical records costs that result from the keeping, for teaching purposes, of more detailed medical records than would otherwise be required. Because our analysis of the data we used to develop the new limits shows that *hospital inpatient operating costs per discharge tend to increase in proportion to increases in hospital levels of teaching activity*, we have adopted a similar adjustment to the new limits..... The increase in the percentage amount of the adjustment ... results from the fact that total *inpatient operating costs*, which include special care unit and inpatient ancillary costs, are more heavily influenced than routine costs by changes in the level of teaching activity. In our opinion, this adjustment accounts for the *additional inpatient operating cost* which a hospital incurs through its operation of an approved intern and resident program." (Emphasis added.)

[9] Pub. Law 98-21 (1983).

[10] 48 Fed. Reg. 39764-39773 (Sept. 1, 1983).

identified and paid as a "pass-through," i.e., paid on a reasonable cost basis.[11] The direct costs of the approved graduate medical education program were paid under the methodology set forth at Section 1886(h) of the Social Security Act. These provisions were promulgated at 42 C.F.R. 413.86 (1997).

However, Congress recognized that teaching hospitals might be adversely affected by implementation of inpatient PPS because of the indirect costs of the approved graduate medical education programs. These may include the increased department overhead as well as a higher volume of laboratory test and similar services as a result of these programs which would not be reflected in the IPPS rates.[12] Thus, under §1886(d)(5)(B) of the Act, hospitals subject to IPPS, with approved teaching programs, receive an additional payment to reflect these IME costs.[13] The statute states that:

> The Secretary shall provide for an additional payment amount for subsection (d) hospitals with indirect costs of medical education, in an amount computed in the same manner as the adjustment for such costs under the regulations (in effect as of January 1, 1983) *under subsection (a)(2)* ... [i.e., RCLs] (Emphasis added.)

The regulation at 42 C.F.R. §412.105 governs IME payments to Medicare providers. The regulation states that CMS "makes an additional payment to hospitals for indirect medical education costs" in part by determining the ratio of the number of FTE residents to the number of beds. The IME adjustment is an add-on to the per case payment which is based upon the standardized amount originally derived from the reasonable operating costs for providing patient care.[14] The resident must be enrolled in an approved teaching program. In addition, the regulation at 42 C.F.R. §412.105(f)(ii) explains that in order to be included in the FTE count, "the resident must be assigned to the portion of the hospital subject to the prospective payment

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[11] Section 1814(b) of the Act.

[12] See 50 Fed. Reg. 35646, 35681 (1985).

[13] This IME payment is distinguished from the direct medical education costs. While GME time spent in research is includable, notably, the original research costs were not allowed in the establishment of the GME base year per resident amount. Thus, the rationale is that a provider will be penalized twice if the time is not allowed in counting the FTE as the costs have already been removed from the calculation.

[14] 42 C.F.R. §412.105(a)(1)(1997). *See* 49 Fed. Reg. 234 (1983) which noted that this additional payment is computed in the same manner as the indirect teaching adjustment under the notice of hospital cost limits published September 30, 1982 (47 Fed. Reg 43310).

system or to the outpatient department of the hospital."[15] Consistent with the foregoing regulation, §2405.3.F of the PRM explains that:

> The term "interns and residents in approved programs" means individuals participating in graduate medical education programs approved as set forth in §404.1.A....
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> It is recognized that situations arise in which it may be unclear whether an individual is counted as an intern or resident in an approved program for the purpose of the indirect medical education adjustment... Intermediaries must not count an individual in the indirect medical education adjustment if any of the following conditions exist:
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> ...
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> The individual is engaged exclusively in research....[16]

Notably, when §1886(d) of the Act was amended to address the additional costs that teaching hospitals incur in treating patients, the Secretary discussed this new formula for IME payments and explained that:

> Section 1886(d)(5)(B) of the Act provides that prospective payment hospitals receive an additional payment for the indirect costs of medical education computed in the same manner as the adjustments for those costs under regulations in effect as of January 1, 1983. Under [the] regulations [then set forth at 42 C.F.R. §412.118], we provided that the indirect costs of medical education incurred by teaching hospitals are the increase operating costs (that is, patient care costs) that are associated with approved intern and resident programs. These increased costs may reflect a number of factors; for example, an increase in the number of tests and procedures ordered by interns and residents relative to the number ordered by more experienced physicians or the need of hospitals with teaching programs to maintain more detailed medical records. [Emphasis added.][17]

Moreover, in a final rule implementing changes to direct GME reimbursement, the Secretary further explained:

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[15] 42 C.F.R. §412.105(f) (1) (1997).

[16] Transmittal Rev. 345 (August 1988).

[17] See 51 Fed. Reg. 16772 (May 6, 1986).

> We also note that section 1886(d) (5) (B) of the Act and section 412.115(b) of our regulations specify that hospitals with "indirect cost of medical education" will receive an additional payment amount under the prospective system. As used in section 1886(d) (5) (B) of the Act, "indirect costs of medical education" means those additional operating (that is, patient care) costs incurred by hospitals with graduate medical education programs.[18] [Emphasis added.]

Finally, the Administrator notes that the Secretary's longstanding policy of requiring hospitals to identify and excluded time spent by residents involved exclusively in research for purposes of the IME count adjustment was codified at 42 C.F.R. §412.105(f)(1)(iii)(B) (2001). Specifically, that section states that "the time spent by a resident in research that is not associated with the treatment or diagnosis of a particular patient is not countable."

Thus, from the beginning of its implementation of the Congressional directives regarding medical education costs, Medicare has only paid for costs related to patient care even within the context of the increased direct and indirect costs associated with approved medical education programs.[19] Consistent with the Act and the regulations at 42 C.F.R. §412.105, the above principles were set forth in the PRM at §2405.3F.2 and state that a resident must not be counted for the IME adjustment if the resident is engaged exclusively in research (i.e., nonpatient care related activities.) The PRM at §504.1 indicates that research conducted in conjunction with or as part of the usual care of patients is reimbursable to the extent such costs are not met by other forms of research funds. If research activity costs were paid by a third party, (not the Medicare program), then no indirect cost should be paid through an IME adjustment. The PRM at §500 indicate that costs incurred for research purposes over and above usual patient care are not includable as reasonable costs or services.

In this case, the parties are disputing the Intermediary's exclusion of 50.86 FTEs from the IME calculation representing the time that residents spent conducting research as part of their approved residency programs. The parties agreed that the research time at issue is not related to patient care. The Provider argued that during the subject cost reporting periods, the regulation at §412.105(f) did not specifically exclude research time from inclusion in the count or require that training be related to patient care. The Provider also argued that, since the residents are in an

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[18] See 54 Fed. Reg. 40282 (Sep. 29, 1989).

[19] See 66 Fed. Reg. 39896 (Aug. 1, 2001) for full recitation of historical overview of policy. For further discussions, See also 71 Fed. Reg. 47870, 48081-48093 (August 18, 2006)

approved residency program, the time residents spend performing research as part of an approved residency program should be included in the IME calculation based upon the pertinent statute and controlling regulations.

Applying the foregoing Medicare law and policy to the facts of this case, the Administrator finds that historically under the reasonable cost system of reimbursement, costs associated with research activities that were not related to patient care were not reimbursed and allowed. This exclusion extended to the indirect education (or teaching) adjustment paid under reasonable cost limits for the higher operating costs incurred by hospitals with medical education programs. The Administrator finds that the indirect teaching adjustment methodology used under the reasonable cost limits was adopted under §1886(d) (5) (B) of the Act. Under both the reasonable cost and IPPS methodology, only the indirect costs of teaching programs relating to patient care (operating costs) is intended to be reimbursed by Medicare. Thus, to the extent that resident time at issue in this case is spent exclusively in research activities (not related to patient care), the time must be excluded from the IME FTE count.[20]

> The Administrator also finds that the regulation at 42 C.F.R. §412.105(f)(5) governing IME explains that in order to be included in the FTE count, the resident must be assigned to the portion of the hospital subject to the prospective payment system or to the outpatient department of the hospital. In this case, the Administrator finds that the Provider failed to demonstrate that the interns and residents were assigned to areas of the hospital subject to the IPPS or to the outpatient department of the hospital as required by 42 CFR 412.105(f)(1)(ii)[21]

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[20] Effective October 1, 1997, section 1886(d)(5)(B)(iv) of the Act was amended to allow a provider to include the time spent by interns and residents in patient care activities in nonhospital settings in the IME count if certain criteria were met. The Administrator disagrees with the Provider's allegation that the omission of similar language in the statutory provision controlling hospital inpatient and outpatient settings supports that nonpatient care related activities may be included in the FTE count. In fact, the statute at section 1886(d)(5)(B) specifically requires that the IME adjustment to be calculated as the medical education adjustment was calculated under the reasonable cost based routine cost limits which again prohibits payment for nonpatient care related costs. Thus, the statute at section 1886(d)(5)(B)(iv) merely makes sure that the expansion to nonhospital settings is limited to patient care related activities consistent with that provided under section 1886(d)(5)(B) and 1886(a)(2) of the Act.

[21] The Administrator also disagrees with the Provider's suggestion in its comments that the Intermediary has stipulated that the Provider has met this criteria. Rather, the stipulation only states that the remaining issue is whether the Intermediary properly excluded time spent in research in determining the

Generally when Medicare refers to the term "area" the program is referring to a "sphere or scope of operation or action" as opposed to a "physical or geographical space."[22] That is, because Medicare is a financing program, for Medicare financing purposes a hospital complex is less about a physical facility and more about how costs flow through the various cost reporting "areas" (IPPS, outpatient, etc.) of the hospital complex. In this instance, the residents at issue were "assigned" to "research," which is not an operational "area" attributable to IPPS or the outpatient department and, thus, these residents cannot be included in the IME count.[23]

Regardless of whether the term "area" is used as a "sphere or scope of operation or action" or a "physical or geographical space", the Provider failed to demonstrate that the residents were assigned to areas "attributable to IPPS or the outpatient department." The Provider alleged that the research training at issue occurred while the residents were assigned to the IPPS and outpatient areas of the hospitals. The Provider claimed that the signed affidavits of the administrators of the Provider's residency program state that the research time occurred in the hospitals complex (Exhibit P-10) The Provider maintained that the term "hospital complex" as used by the Provider "generally means the main hospital building and outpatient clinics." The Provider argued that the areas within the hospital complex that are excluded from IPPS are Ward 4 (inpatient psychiatric ward) and the general clinical research center, which is a nonreimbursable cost center. As no residents were included that trained at either location and, all residents train in the hospitals

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Provider's count of FTEs for purposes of calculating the Provider's IME payment and that the 51.81 FTEs would meet all applicable requirements for inclusion in the Provider's FTE count. In fact, the Intermediary and Provider specifically briefed, in their final position papers, as a sub-issue contained within the "research" issue, whether the interns and residents met the criteria of 42 CFR 412.105(f)(1)(ii). (See Intermediary Final Position Paper, pp. 18-20, Provider's Final Position Paper, p. 40) Moreover, the Intermediary would not be authorized to bind the agency on a matter if it were found to be contrary to the law.

[22] See also the analysis of the alternative use of the term "area" as geographical in District Memorial Hospital v. Thompson, 364 F.3d 513, 519-520 (4th Cir. 2004)(Although the reimbursement status of each swing bed might thus change daily, as the use of the bed shifted between acute care and skilled nursing care, such a daily reassessment would be consistent with the regulatory language, which refers to "*days* attributable to areas of the hospital that are subject to the prospective payment system." 42 C.F.R. §412.106(a)(1)(ii) (1988).")

[23] That the use of the term "area" is referring the "scope of operations" is also supported by the use of the term "assigned" which again is an "operational" term not a "geographical" term.

complex, the Provider concluded that all residents are assigned to areas subject to inpatient IPPS or the outpatient department. However, logic does not support a conclusion that if a resident is performing the rotation at the hospitals complex, it is necessarily assigned to the IPPS area or an outpatient department. As a general rule, a hospital complex consists of more than just an inpatient area subject to IPPS and an outpatient department.[24] Thus, the term hospital complex cannot be reasonably limited to mean only inpatient and outpatient departments.

In addition, the record in this case shows that the "hospitals complex" consisted of more than the foregoing areas acknowledged by the Provider in its use of that term. The record shows several affidavits of the administrators. Some affidavits showed that the residents were conducting research in "University of Chicago Hospitals complex."[25] Some affidavits showed that the residents were conducting research at: the University of Chicago Hospitals complex "Laboratory" (Drs. Aksentijevich and Luisiri); the University of Chicago Hospitals complex Pharmacology lab located in the Hospitals complex (Dr Chang) and the University of Chicago Hospitals complex Psychomotor Lab located in the Hospitals complex.[26] Thus, based on these affidavits alone, the Provider's statement that the residents listed as conducting research in the hospitals complex must necessarily be assigned to the inpatient and outpatient areas is inaccurate. The designation that a resident's rotation location was the "University of Chicago Hospitals Complex" is not dispositive of whether the residents were assigned to IPPS or outpatient areas. The Administrator concludes that the designation of a resident as conducting research at the "hospitals complex" does not demonstrate that the residents were "assigned to areas of the hospital subject to the IPPS or to the outpatient department of the hospital" as required by 42 CFR 412.105(f)((1)(ii).

[24] See for e.g., Hospital Complex cost report form. The Provider's cost report was not included in the record.

[25] Notably, the hospital auditor suggested, in requesting research assignment schedules from the department heads, that the ideal scenario would be for the residents to be assigned to the "medical center." Provider Exhibit P-10.

[26] Consequently, the Provider's suggestion that there is one nonreimbursable cost center in the hospitals complex is also inaccurate.

DECISION

The decision of the Board is reversed in accordance with the foregoing opinion.

THIS CONSTITUTES THE FINAL ADMINISTRATIVE DECISION OF THE SECRETARY OF HEALTH AND HUMAN SERVICES.

Date: 10/5/07

/s/
Herb B. Kuhn
Acting Deputy Administrator
Centers for Medicare & Medicaid Services