CENTERS FOR MEDICARE AND MEDICAID SERVICES
Decision of the Administrator

In the case of:	**Claim for:**
St. Vincent Randolph Hospital, Inc.	**Provider Cost Reimbursement Determination for Cost Reporting Periods Ending: 2004-2008**
Provider	
vs.	
Wisconsin Physician Services/ Blue Cross and Blue Shield Association	**Review of: PRRB Dec. No. 2015-D2**
Intermediary	**Dated: February 5, 2015**

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 mandated in §1878(f)(1) of the Social Security Act (Act), as amended (42 U.S.C. §1395oo(f)). The Intermediary and the Center for Medicare requested review by the Administrator. Accordingly, this case is now before the Administrator for final agency review.

ISSUE

The issue involves whether the Intermediary's[1] disallowance of the interest expense for the Provider's 2004, 2005, 2006, 2007, and 2008 fiscal years was proper.

BOARD'S DECISION

The Board held that the Intermediary's disallowance of interest expense for the Provider's cost reporting periods for fiscal years 2004 to 2008 was improper, and reversed the Intermediary's adjustments.

[1] Formerly known as Fiscal Intermediaries (FIs), CMS' payment and audit functions under the Medicare program are now contracted to organizations known as Medicare Administrative Contractors (MACs). However, for the cost year at issue in this case, the term "Intermediary" will be used.

The Board stated the issues it had to decide in this case were whether changing the source of a loan from a related party to a religious order cures the "borrower-lender relationship" prohibition of 42 C.F.R. § 413.135(c), making the interest expense an allowable cost from that point forward based on the Motherhouse exception in (c)(2) of the regulation. Further, if the change of the source of the loan cured this prohibition. A second issue was whether the Provider submitted sufficient documentation to support reimbursement for the interest paid on the loan from Ascension Health.

The Board found that the regulations governing Medicare reasonable cost reimbursement, including those at 42 C.F.R. 413.153(c), neither prohibit nor preclude a provider from changing the source of its borrowed funds, and further, that these regulations do not prohibit the curing of a nonallowable related-party interest expense through refinancing of the loan with a third party lender or Motherhouse. Therefore, the Board concluded that the loan between St. Vincent Randolph and Ascension Health qualified under the "Motherhouse" exception at 42 C.F.R. § 413.153(c)(2).

The Board then applied the Motherhouse exception to the case, and found that there was sufficient evidence to document that the original loan between St. Vincent Randolph and St. Vincent's Hospital Indianapolis was paid off as of July 1, 2003, thereby curing the tainted funds, and also that there was sufficient evidence to document that Ascension Health qualified as a Motherhouse and that Ascension Health made the loan at issue to St. Vincent Randolph. Thus, the Board concluded that the interest that St. Vincent Randolph paid on the loan from Ascension Health was an allowable cost.

SUMMARY OF COMMENTS

The Intermediary requested that the Administrator review the Board's decision. The Intermediary noted that the interest expense was disallowed on the grounds that the 2002 loan was made between related parties, rendering interest paid relating to this and related loans unallowable under 42 C.F.R. 413.53(c)(1). The Intermediary also stated that the Provider failed to produce sufficient documentation to support the loans under 42 C.F.R. §§ 413.20 and 413.24.

The Intermediary maintained that the Board made erroneous interpretations of laws and regulations in its decision, and that the interest should be disallowed because it stems from the 2002 related party loans. The Intermediary also argued that the Provider's documentation was insufficient. The regulation at 42 C.F.R. § 413.53(a)(1) allows "necessary and proper interest on both current and capital

indebtedness." The Intermediary noted that necessary interest is interest that is incurred on a loan made to satisfy a financial need of the provider and is incurred on a loan made for a purpose reasonably related to patient care.[2] Proper interest is interest that is incurred at a rate not in excess of what a prudent borrower would have had to pay in the money market existing at the time the loan was made and was paid to a lender not related through control or ownership, or personal relationship to the borrowing organization.[3] The Intermediary stated that the documentation the Provider submitted was insufficient to establish that the loans were necessary and proper under these standards. The Intermediary noted that the Provider took the 2003 loan after it finished construction on its facility, and there is no evidence in the record that satisfies the Provider's burden of proving that this loan was necessary and proper under the regulation.

The Chronic Care Policy Group, Center for Medicare (CM) also submitted comments, requesting that the Administrator reverse the Board's decision. CM noted that the Provider failed to meet its documentation requirements at 42 C.F.R. §§ 413.20 and 413.24 in order to show that the loan was necessary, proper and related to patient care pursuant to 42 C.F.R. §§ 413.9 and 413.153.

The Provider commented, noting that the Board's decision was based on the conclusion that nothing prevents a provider from changing the source of its debt/borrowed funds, and nothing in the regulations prevent the curing of non-allowable related party debt through refinancing the loan with a third party or Motherhouse. The Provider stated that it originally received a loan from its sister hospital at the direction of both hospitals' sponsoring religious congregation, the Daughters of Charity, which was in the process of forming Ascension Health. Now, the Provider noted, Ascension Health is the largest Catholic health care system in the United States. The Provider noted that its facility was eighty years old, crumbling, not up to current building standards, and not able to properly fulfill the critical health care need in rural Randolph County, Indiana. The Provider stated that there is arguably "no more necessary and proper indebtedness in health care than for the construction and maintenance of critical access hospitals to fill those vita roles in their respective communities."

The Provider noted that the Intermediary and CM, in their comments to the Administrator, "devoted much effort advocating their shared belief that the refinancing of the original loan and incorporating the debt into Ascension Health's bond issuance does not make the interest expense allowable", under the theory that since the initial loan from the sister hospital was undocumented, and thus

[2] 42 C.F.R. § 413.53(b)(2).
[3] 42 C.F.R. § 413.53(b)(3).

unallowable, any loan after that would also be "tainted". However, the Provider argued, the interest expense related to the interim loan is not part of its claim for the years subject to the Board's decision. Instead, it is only seeking to claim interest related to the payments it made as a member of the Ascension Obligated Bond Group beginning in its 2004 fiscal year. The Provider claimed that neither the Intermediary nor CM could cite any regulatory or legal support for the "once unallowable, always unallowable" principle, as no such support exists. The Provider argued that the Medicare program guidelines expressly allow for the cost or refinancing debt to be reimbursed, underscoring the fact that refinanced debt is itself allowable.[4] Additionally, the Provider noted, the Provider Reimbursement Manual has provisions dealing with refinancing costs resulting in allowable interest expense.[5]

The Provider further argued that the Intermediary and CM's position that lack of a formal loan agreement automatically deems a loan unallowable is contrary to the Board's long-held position that interest expense can be allowable even absent a formal agreement.[6] The Provider stated that it supplied "ample materials documenting the initial loan from the sister hospital, which demonstrated the amount of the loan, the fact that interest was paid on the loan and the pay-off of the initial loan." The Provider noted that the Board was provided documentation of the Provider's construction costs for the new facility[7], all of the documentation related to the initial loan from St. Vincent Indianapolis[8], satisfaction of the initial loan from St. Vincent Indianapolis[9], and documentation regarding the Provider's participation in the Ascension Health Obligated Group from July 1, 2003 through the fiscal years covered by the appeals[10].

The Provider stated that the Board also heard testimony at the Oral Hearing from St. Vincent Health's Chief Operating Office and Executive Director of Operations, both of whom were involved in the process to build the Provider' new facility, and assisted with the financing of that facility. The Provider argued that the documentation and testimony support the basic terms of the initial loan, the limited purpose of the initial loan, the repayment of the original loan, and the Provider's new debt that was incorporated into Ascension Health's Obligated Bond Group.[11] As of

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[4] The Provider cited to 42 C.F.R. § 413.130(a)(10).
[5] The Provider cited to CMS Pub. 15-1 § 233.
[6] The Provider cited to *All Saints Hosp. v. Blue Cross Blue Shield*, PRRB Dec. No. 79-D63 (Oct. 9, 1979).
[7] Provider's Exhibit P-56.
[8] Provider's Exhibits P-1, P-47, and P-48.
[9] Provider's Exhibits P-57 through P-64.
[10] Provider's Exhibits P-2 and P-3.
[11] The Provider cited to Exhibits P-57 through P-64.

July 1, 2003, the Provider noted, it began paying Ascension Health for its proportionate share of the bond obligations Ascension Health undertook on the Provider's behalf, and as of this date, the interest expenses associated with the refinance debt would be allowable under Medicare regulations and guidance.

The Provider noted that this case is not the first time the Board has considered the interest expenses on refinanced debt. In *Prof'l Home Care of Wash., Inc. v. Blue Cross and Blue Shield Ass'n*[12], the original loan was from a related party. In that case, the Board determined that the change in the source of the loan from a related party to a commercial lending institution resulted in the refinanced loan being allowable for purposes of Medicare program reimbursement. The Board stated that it could find no prohibition in the regulations to preclude a provider from changing the source of its borrowed funds, nor any regulation that requires interest expense on refinanced related party loans to remain tainted by the previous financial arrangement.

The Provider concluded by arguing that even if the interest expenses could not be allowed under the Motherhouse exception, at the point the Provider's debt became incorporated into Ascension Health's bond financing, the interest became allowable under the PRM and regulations. The Provider stated that it submitted "comprehensive documentation" to the Board, supported by the testimony of several witnesses concerning the Provider's participation in the Ascension Bond Group, and that "none of that evidence was contested, much less refuted". Thus, the Provider noted, beginning July 1, 2003, the interest expense should have been allowed.

DISCUSSION

The entire record, which was furnished by the Board, has been examined, including all correspondence, position papers, exhibits, and subsequent submissions. The Administrator has reviewed the Board's decision. All comments timely submitted have been taken into consideration.

Section 1815(a) of the Act provides documentation requirements from Providers, stating:

> The Secretary shall periodically determine the amount which should be paid under this part to each provider of services with respect to the

[12] PRRB Dec. No. 95-D45. Rev'd, Administrator. Administrator decision overruled and Board decision upheld by Federal District Court for the District of Minnesota. *In Home Health, Inc., as successor to Prof'l Home Care of Wash, Inc. d/b/a/ Wash. Home Care v. Shalala*, 1996 WL 393653 (May 30, 1996).

> services furnished by it, and the provider of services shall be paid, at such time or times as the Secretary believes appropriate (but not less often than monthly) and prior to audit or settlement by the General Accounting Office, from the Federal Hospital Insurance Trust Fund, the amounts so determined, with necessary adjustments on account of previously made overpayments or underpayments; *except that no such payments shall be made to any provider unless it has furnished such information as the Secretary may request in order to determine the amounts due such provider under this part* for the period with respect to which the amounts are being paid or any prior period. (Emphasis added.)

Section 1861(v)(1)(A) of the Act establishes that Medicare pays for the reasonable cost of furnishing covered services to program beneficiaries, subject to certain limitations. Section 1861(v)(1)(A) defines reasonable cost as "the cost actually incurred, excluding therefrom any part of incurred cost found to be unnecessary in the efficient delivery of needed health services." The Act further authorizes the Secretary to promulgate regulations establishing the methods to be used and the items to be included in determining such costs. Section 1861(v)(1)(A) also states that the necessary costs of delivering covered services to Medicare beneficiaries will not be borne by non-Medicare beneficiaries and vice-versa (i.e., Medicare prohibits the cross-subsidization of costs).

The regulation at 42 C.F.R. § 413.9(a) sets forth that all payments to providers must be based on the reasonable cost of services covered under Medicare and related to patient care. Paragraph (b)(1) and (2) of 42 C.F.R. § 413.9 sets forth the definitions of reasonable cost and necessary and proper costs. In particular, necessary and proper is defined as "costs that are appropriate and helpful in developing and maintaining the operation of patient care facilities and activities. They are usually costs that are common and accepted occurrences in the field of the provider's activity."

The regulation at 42 C.F.R. § 413.153(a)(1) provides that "necessary and proper interest on both current and capital indebtedness is an allowable cost." Defining the term "necessary," 42 C.F.R. § 413.153(b) notes that:

> (2) *Necessary*. Necessary interest is interest that meets the following requirements:
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> (i) It is incurred on a loan made to satisfy a financial need of the provider. Loans that result in excess funds or investments would not be considered necessary.

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

Defining the term "proper," 42 C.F.R. § 413.153(b) provides:

> (3) Proper. Proper requires that interest be—
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> (i) Incurred at a rate not in excess of what a prudent borrower would have had to pay in the money market existing at the time the loan was made; and
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> (ii) Paid to a lender *not related through control or ownership*, or personal relationship to the borrowing organization. However, interest is allowable if paid on loans from the provider's donor-restricted funds, the funded depreciation account, or the provider's qualified pension fund. (Emphasis added.)

Regarding the relationship between the borrower and lender, 42 C.F.R. § 413.153(c) states:

> (c) Borrower-lender relationship. (1) Except as described in paragraph (c)(2) of this section, to be allowable, interest expense must be incurred on indebtedness established with lenders or lending organizations not related through control, ownership, or personal relationship to the borrower. Presence of any of these factors could affect the ''bargaining'' process that usually accompanies the making of a loan, and could thus be suggestive of an agreement on higher rates of interest or of unnecessary loans. Loans should be made under terms and conditions that a prudent borrower would make in armslength transactions with lending institutions. The intent of this provision is to assure that loans are legitimate and needed, and that the interest rate is reasonable. Thus, interest paid by the provider to partners, stockholders, or related organizations of the provider would not be allowable. If the owner uses his own funds in a business, it is reasonable to treat the funds as invested funds or capital, rather than borrowed funds. Therefore, if interest on loans by partners, stockholders, or related organizations is disallowed as a cost solely because of the relationship factor, the principal of such loans is treated as invested funds in the computation of the provider's equity capital under § 413.157.

Accordingly, interest paid to partners, stockholders, or related organizations of the provider is not a proper, allowable Medicare cost.[13]

The regulation at 42 C.F.R. § 413.20(a) generally provides that the principles of cost reimbursement requires that providers maintain sufficient financial records and statistical data for proper determination of costs payable under the program. Paragraph (d) of 42 C.F.R. § 413.20 explains the continuing recordkeeping requirements of providers, noting in particular that the provider must furnish such information to the intermediary as may be necessary to assure proper payment, and specifies:

> (2) The provider must permit the intermediary to examine such records and documents as are necessary to ascertain information pertinent to the determination of the proper amount of program payments due. These records include, but are not limited to, matters pertaining to—
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> (i) Provider ownership, organization, and operation;
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> (ii) Fiscal, medical, and other recordkeeping systems;
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> (iii) Federal income tax status;
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> (iv) Asset acquisition, lease, sale, or other action;
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> (v) Franchise or management arrangements;
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> (vi) Patient service charge schedules;
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> (vii) Costs of operation;
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> (viii) Amounts of income received by source and purpose; and
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> (ix) Flow of funds and working capital.

Regarding adequate cost data, 42 C.F.R. § 413.24(a) notes:

> (a) Principle. Providers receiving payment on the basis of reimbursable cost must provide adequate cost data. This must be based on their financial and statistical records which must be capable of verification

[13] *Goleta Valley Community Hospital v. Schweiker*, 647 F.2d 894 (9th cir. 1981); *The Regents of the University of California v. Shalala*, 872 F. Supp. 728 (D. Cal. 1994).

> by qualified auditors. The cost data must be based on an approved method of cost finding and on the accrual basis of accounting.

The regulation at 42 C.F.R. § 413.24(c) states:

> (c) Adequacy of cost information. 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, whether it is operated for profit or on a nonprofit basis. It is a reasonable expectation on the part of any agency paying for services on a cost-reimbursement basis. In order to provide the required cost data and not impair comparability, financial and statistical records should be maintained in a manner consistent from one period to another. However, a proper regard for consistency need not preclude a desirable change in accounting procedures if there is reason to effect such change.

In addition to the statutory and regulatory provisions, interpretive guidelines for claiming interest expense on cost reports are published in the Provider Reimbursement Manual (PRM), Pub. 15-1 in Chapter 2. In pertinent part, it states:

> 202.1 Interest.--Interest is the cost incurred for the use of borrowed funds, generally paid at fixed intervals by the user. Interest on current indebtedness is the cost incurred for funds borrowed for a relatively short term, usually for 1 year or less. Current borrowing is usually for purposes such as working capital for normal operating expenses. Interest on capital indebtedness is the cost incurred for funds borrowed for capital purposes, such as the acquisition of facilities, equipment, and capital improvements. Generally, loans for capital purposes are long-term loans.
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> Interest is usually expressed as a percentage of the principal. Sometimes, it is identified as a separate item of cost in a loan agreement. Interest may be included in finance charges imposed by some lending institutions or it may be a prepaid cost or discount in transactions with those lenders who collect the full interest charges when funds are borrowed. Reasonable finance charges and service

charges together with interest on indebtedness are includable in allowable cost.

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

- *Supported by evidence of an agreement that funds were borrowed and that payment of interest and repayment of the funds are required*;

- *Identified in your accounting records*;

- Related to the reporting period in which the costs are incurred; and

- Necessary and proper for the operation, maintenance, or acquisition of your facilities.

To support the existence of a loan, have available a signed copy of the loan contract which contains the pertinent terms of the loan such as amount, rate of interest, method of payment, due date, etc. Where the lender does not customarily furnish a copy of the loan contract, correspondence from the lender stating the pertinent terms of the loan such as amount, rate of interest, method of payment, due date, etc., is acceptable.

Where funds are borrowed from your funded depreciation account or other restricted funds, authorization from your appropriate officials must be on file. Your appropriate officials include the persons to whom responsibility for the management of the restricted amounts or funds has been granted, such as the board of trustees, financial committees, or other individuals or groups, as appropriate in the particular case.

Various methods of identifying and accounting for interest costs are used. These include periodic cash payments of interest with or without repayment of all or part of the loan; prepayment of interest when the liability is incurred with charges to interest expense recorded in relation to the accounting period; and accrual of interest with no cash payment with a corresponding record of the unpaid liability reflected in the accounting records. The method actually used depends on the type of loan and the terms of the loan agreement.

> Where interest expense has been determined to be allowable and the interest expense records are maintained physically away from your premises, such as in a county treasurer's office, such records are deemed to be yours. This is applicable where bond issues have been specifically designated for the construction or acquisition of your facilities and the financial records relative to the bond issue are maintained by some governmental body other than you. (Emphasis added).

Regarding the interest on loans from lenders that are related to the provider, the PRM notes in § 218:

> One of the elements required for interest to be "proper" is that the interest be paid to a lender not related through control, ownership, or personal relationship to the borrowing organization. (See Chapter 10 for the definition of control and ownership.) Presence of any of these factors could affect the "bargaining" process that usually accompanies the making of a loan, and could thus be suggestive of an agreement for higher rates of interest or for unnecessary loans. This provision is intended to assure that loans are legitimate and needed, and that the interest rate is reasonable. Exceptions to this general rule are contained in §§218.2 and 220.

Section 220 of the PRM provides the "Mother house" exception, which states:

> Providers owned and operated by members of religious orders often obtain funds through loans from the Mother House or Governing Body of the religious order. Where there is a *contractual agreement for the payment of interest, and for the eventual repayment of the loan*, the interest expense is allowable as cost provided the interest is applicable to the period after the certification of the institution as a provider. Interest expense incurred during a reporting period must be paid within the succeeding reporting period. (Emphasis added.)

In this case, the Provider, St. Vincent Randolph Hospital, Inc., is a hospital licensed by the State of Indiana and a corporate subsidy of St. Vincent Health, which itself is a subsidiary of Ascension Health.[14] St. Vincent Health began the process of acquiring the former Randolph County Hospital is 1999, and formed St. Vincent Randolph Hospital, Inc.[15] At the time St. Vincent Randolph was incorporated to become the

[14] *See* Provider's Final Position Paper, p. 1.
[15] *Id.*

operator of the former county hospital, St. Vincent Health was also operating another hospital, St. Vincent Hospital & Health Care Center.[16] St. Vincent Randolph's acquisition by St. Vincent Health was finalized in 2000, shortly after Ascension Health was formed.[17] Shortly after St. Vincent Randolph became affiliated with St. Vincent Health and Ascension Health, St. Vincent Randolph borrowed funds from St. Vincent Health to be used for the construction of a new hospital facility and subsequently an addition to the Hospital.[18] The Provider admits that a formal loan agreement was not drafted at that time.[19] An Amortization Table dated 10/09/2002 is the only evidence of the terms of the loan.[20] In 2002, Ascension Health undertook a bond issuance that included a portion of the costs of the St. Vincent Randolph construction as one of its purposes.[21] In 2003, Ascension Health undertook another bond issuance that was to cover costs associated with the development of St. Vincent Randolph. At that time, St. Vincent Randolph became a part of the obligated group under the Ascension Health bond covenants, and agreed to pay interest on the funds advanced to it.[22] In 2005, a portion of the Ascension Health debt was refinanced.[23] Following the 2005 bond issuance, St. Vincent Randolph Hospital, along with all other affiliated hospitals in the Ascension Health system, were required to pay interest pursuant to the bond obligations.[24]

The Administrator finds that the documentation submitted by the Provider was insufficient to establish that the loans were necessary and proper and related to patient care. The Provider did not produce a signed loan contract for the first loan between related providers. The only evidence of the terms of the loans were amortization tables. Thus, the initial loan between the Provider and St. Vincent Health was not "proper" according to the regulations or the PRM. Additionally, the Provider did not submit sufficient evidence to establish that the initial loan was paid off by the bonds, nor did they provide sufficient evidence as to what interest payments were attributable to the initial loan. Thus, the Administrator finds that the Intermediary's disallowance of the interest expense for the Provider's 2004, 2005, 2006, 2007, and 2008 fiscal years was proper.

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[16] *Id.*at 2.
[17] *Id.*
[18] *Id.*
[19] *Id.*
[20] *See* Provider's Exhibit P-1.
[21] *See* Provider's Exhibit P-46.
[22] *See* Provider's Exhibit P-2.
[23] *See* Provider's Exhibit P-3.
[24] *See* Provider's Final Position Paper, p. 3.

DECISION

The Administrator reverses the Board's decision in accordance with the foregoing decision.

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

Date: 4/1/15 /s/

Patrick H. Conway, M.D., MSc
Acting Principal Deputy Administrator
Centers for Medicare & Medicaid Services