PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2006-D5

PROVIDER -
Rush-Presbyterian-St. Luke's Medical Ctr.
Chicago, Illinois

Provider No.: 14-0119

vs.

INTERMEDIARY -
BlueCross BlueShield Association/
AdminaStar Federal

DATE OF HEARING -
June 12, 2002

Cost Reporting Period Ended -
June 30, 1991

CASE NO.: 94-2729

INDEX

ISSUES:

1. Whether the Intermediary's adjustment to and calculation of the Provider's disproportionate share hospital payment (DSH) was proper, specifically relating to the inclusion of general assistance days.

2. Whether the Intermediary's calculation of the number of interns and residents and the amount of allowable costs for fiscal year 1991 for purposes of the Provider's graduate medical education programs (GME) was proper.

3. Should the Intermediary have reclassified expenses relating to the Inn at University Village as investment losses and offset such losses against investment income rather than disallowing them entirely?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

This is a dispute over the amount of Medicare reimbursement due a health care provider.

The Medicare program provides health insurance to the aged and disabled. 42 U.S.C. §§1395-1395cc. The Centers for Medicare & Medicaid Services (CMS), formerly the Health Care Financing Administration (HCFA), is the operating component of the Department of Health and Human Services (DHHS) charged with the Medicare program's administration. CMS' payment and audit functions under the Medicare program are contracted out to insurance companies known as fiscal intermediaries. Fiscal intermediaries determine payment amounts due providers under Medicare law and interpretative guidelines published by CMS. See, 42 U.S.C. §1395(h), 42 C.F.R. §§413.20(b) and 413.24(b).

At the close of its fiscal year, a provider must submit a cost report to the fiscal intermediary showing the costs it incurred during the fiscal year and the portion of those costs to be allocated to Medicare. 42 C.F.R. §413.20. The fiscal intermediary reviews the cost report, determines the total amount of Medicare reimbursement due the provider, and issues the provider a Notice of Program Reimbursement (NPR). 42 C.F.R §405.1803. A provider dissatisfied with the intermediary's final determination of total reimbursement may file an appeal with the Provider Reimbursement Review Board (Board) within 180 days of the NPR. 42 U.S.C. §1395oo(a); 42 C.F.R. §405.1835.

Rush University Medical Center (Provider) is a large, acute care, teaching hospital located in Chicago, Illinois. Health Care Service Corporation (Intermediary)[1] reviewed the Provider's cost report for its fiscal year ended June 30, 1991 and made several adjustments reducing the Provider's program reimbursement. In addition, the Intermediary excluded general assistance days from the Provider's DSH calculation, which decreased the Provider's program reimbursement under the DSH payment methodology. The Provider appealed these issues to the

[1] AdminaStar Federal subsequently replaced Health Care Service Corporation as the Provider's intermediary.

Board pursuant to 42 C.F.R.§§ 405.1835-405.1841 and met the jurisdictional requirements of those regulations. The amount of Medicare funds in controversy exceeds $1,000,000.

The Provider was represented by James F. Flynn, Esq., of Bricker & Eckler LLP. The Intermediary was represented by Bernard M. Talbert, Esq., Associate Counsel, Blue Cross Blue Shield Association.

BACKGROUND OF THE ISSUES AND PARTIES' CONTENTIONS

Issue No. 1-Disproportionate Share

Short-term acute care hospitals, such as the Provider, are reimbursed under Medicare's Prospective Payment System (PPS) for inpatient hospital services. The Provider is entitled to additional Medicare payments, however, if it serves a disproportionate number of low-income patients (DSH adjustment). 42 U.S.C. § 1395ww(d)(5)(F)(i)(I). Whether a hospital qualifies for the DSH adjustment, and how large an adjustment it receives, depends on its "disproportionate patient percentage," which is the sum of two calculations. The first calculation, or Medicare fraction, is the number of the hospital's patient days that were furnished to patients who were entitled to both Medicare Part A and Supplemental Security Income (SSI) divided by the number of covered patient days utilized by patients under Medicare Part A for a cost reporting period. The second calculation, or Medicaid fraction, is the number of the hospital's patient days consisting of patients who were eligible for medical assistance under a State plan approved under Title XIX but who were not eligible for Medicare Part A (referred to as "Title XIX" or "Medicaid days") divided by the hospital's total number of patient days for that period. 42 U.S.C. § 1395ww(d)(5)(F)(vi).

Initially, CMS maintained that Medicaid days included only those days for which the hospital received Medicaid payment for inpatient hospital services. However, after several circuit court rulings, CMS issued Ruling 97-2 in February, 1997 holding that Medicaid days should also include those days for which a patient was "eligible" for Medicaid benefits even if the hospital received no Medicaid payment for its services.

In addition, on December 1, 1999 CMS issued Program Memorandum A-99-62 which clarified what days should and should not be included in the Medicaid fraction for cost reporting periods beginning on or after January 1, 2000. The memorandum also memorialized a "hold harmless" provision that CMS had previously established in October, 1999 regarding DSH program payments made to hospitals for cost reporting periods beginning before January 1, 2000 attributable to the "erroneous inclusion of general assistance or other State-only health program . . . days" in the Medicaid fraction. In part, the memorandum explained that most hospitals and intermediaries relied upon Medicaid days data obtained from Medicaid State agencies to compute Medicare DSH payments and that some of those agencies commingled otherwise ineligible days with eligible Title XIX days.

The issue in this case is whether the Provider is entitled to the hold harmless provision of Program Memorandum A-99-62.[2] In pertinent part, the memorandum states:

> If, for cost reporting periods beginning before January 1, 2000, a hospital that did not receive payments reflecting the erroneous inclusion of otherwise ineligible days filed a jurisdictionally proper appeal to the PRRB *on the issue of the exclusion of these types of days from the Medicare DSH formula* before October 15, 1999, reopen the cost report at issue and revise the Medicare DSH payment to reflect the inclusion of these types of days as Medicaid days. Where, for cost reporting periods beginning before January 1, 2000, a hospital filed a jurisdictionally proper appeal to the PRRB on the issue of the exclusion of these types of days from the Medicare DSH formula *on or after* October 15, 1999, reopen the *settled* cost report at issue and revise the Medicare DSH payment to reflect the inclusion of these types of days as Medicaid days, but only if the hospital appealed, before October 15, 1999, the denial of payment for the days in question in previous cost reporting periods. . . . (emphasis in original)
>
> You are to continue paying the Medicare DSH adjustment reflecting the inclusion of general assistance or other State-only health program, charity care, Medicaid DSH, and/or waiver or demonstration population days for all open cost reports for cost reporting periods beginning before January 1, 2000, to any hospital that, before October 15, 1999, filed a jurisdictionally proper appeal to the PRRB specifically for this issue on *previously* settled cost reports. (emphasis in original)

The Provider contends that it is entitled to have 4,034 general assistance days included in its DSH calculation, which would increase its Medicare reimbursement by approximately $946,000.[3] The Provider asserts that it met the qualifying provisions of Memorandum A-99-62 quoted above, i.e., it did not receive payment reflecting the inclusion of general assistance days; it properly appealed the exclusion of general assistance days based upon language included in its April 1, 1998 position paper filed with the Board; and, its cost report is already open by virtue of its appeal.[4] Moreover, the Provider asserts that even if it is determined that the language used in its appeal was not specific enough with respect to "general assistance days," it still qualifies for the hold harmless provision because it did specifically appeal the exclusion of these days in its 1989 and 1990 cost reporting periods (PRRB Case Nos. 92-1678 and 92-1717).[5]

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[2] Exhibit P-7.
[3] Provider's Post Hearing Brief at 3.
[4] Provider's Post Hearing Brief at 7.
[5] Provider's Post Hearing Brief at 8. Exhibits P-9 and P-10.

The Intermediary contends that the Provider was not specific enough in appealing the exclusion of general assistance days to qualify for the hold harmless provision of Memorandum A-99-62.[6] Moreover, the Intermediary contends that the Provider's 1989 and 1990 appeals bear no relevance to the instant case. Even though the Provider did specifically appeal the exclusion of general assistance days in those prior period DSH calculations, those appeals were settled in an Administrative Resolution without the inclusion of those days in the Provider's DSH calculation.

Issue No. 2- Graduate Medical Education

Under PPS, Medicare pays for Part A inpatient operating costs on a per-discharge basis. In general, Medicare discharges are classified into diagnostic related groups (DRG) and a specific payment rate is assigned to each DRG based upon resource intensity. The specific costs reimbursed under a DRG include general routine service costs, ancillary service costs, and intensive care-type service costs but exclude certain other expenses, including the direct and indirect costs of graduate medical education programs, which are paid separately. In general, a hospital's direct GME costs are determined by multiplying its "average per resident amount," a hospital specific rate that had been determined from a base period (42 U.S.C. §1395ww(h)(2)(A), times the number of full-time equivalent (FTE) residents that worked at the facility pursuant to 42 U.S.C. §1395ww(h)(4). These costs are then apportioned to Medicare based upon a hospital's ratio of Medicare inpatient days to total inpatient days. Implementing regulations at 42 C.F.R. §413.86(f) provide specific rules for counting FTE residents for GME.

Authority for the payment of indirect medical education (IME) costs is found at 42 U.S.C. §1395ww(d)(5)(B). In general, the statute explains that a hospital's adjustment for IME is calculated by multiplying its total DRG revenue by its ratio of FTE residents to its number of beds. Implementing regulations at 42 C.F.R. §412.105(f) provide the rules for counting FTE residents for this purpose.

A hospital's medical education training programs must be *approved* in order for the hospital to be reimbursed for its GME and IME costs. 42 U.S.C. §1395ww(h)(5)(A). Regulations at 42 C.F.R. §413.86(b) define an "approved medical residency program" as a program that:

- is approved by one of the national organizations listed in 42 C.F.R. 405.522(a);
- may count towards certification in a specialty or subspecialty listed in the Directory of Residency Training Programs published by the American Medical Association; or
- is approved by the Accreditation Council for Graduate Medical Education (ACGME).

The Intermediary disallowed a number of FTE residents claimed by the Provider because the residents participated in a medical education fellowship program that was not approved pursuant to 42 C.F.R. §413.86(b). In some instances the programs were approved but not until after the subject cost reporting period, and in other instances the programs were approved but not by

[6] Intermediary Revised Final Position Paper at 4.

an organization recognized by program rules.[7] The Intermediary also disallowed FTEs associated with three specific residents for GME purposes and five specific residents for IME for different documentation concerns. Doctors Lakshman, Abusharif, and Soltes are at issue for GME, and doctors Wong, Myles, Kaskel, Abrams, and Muhsin are at issue for IME.

With respect to these disallowances, the Intermediary contends that residents must participate in a medical education training program approved by one of the organizations addressed in 42 C.F.R. §413.86(b) in order to be counted for either GME or IME. Approval by any other organization is unacceptable, and approval obtained by a recognized approving body after the subject cost reporting period cannot be applied retroactively. The Intermediary also contends that the costs of the residents associated with the disallowed FTEs cannot be reimbursed through Supplemental Worksheet D-2 of the Medicare cost report, Apportionment of Cost of Services Rendered by Interns and Residents, because the Provider did not maintain the detailed documentation needed to complete the worksheet.[8] Provider Reimbursement Manual, Part II (HCFA Pub. 15-2) §2426.[9] Moreover, the Intermediary asserts that the FTEs associated with the residents specifically named above are properly disallowed in accordance with program rules.

The Provider contends that each of the medical education training programs at issue in this case is an approved program within the statutory definition at 42 U.S.C. §1395ww(h)(5)(A), which states:[10]

> [t]he term "approved medical residency training program" means a residency or other postgraduate medical training program participation in which may be counted toward certification in a specialty or subspecialty and includes formal postgraduate training programs in geriatric medicine approved by the secretary.

The Provider also contends that, at a minimum, the FTEs associated with eight of the programs should be allowed during the subject cost reporting period because fellowship programs were just evolving at the time and there was not always an approving body in place during the cost reporting period, or the approving body was not yet listed in the program's rules. The Provider notes that each of these eight programs was eventually approved by the ACGME.[11]

The Provider maintains that it has furnished documentation to substantiate that 2.16 additional FTEs for Doctors Lakshman, Abusharif and Soltes should be added to its GME count and 5.0 additional FTEs added to its IME count for Doctors Wong, Miles, Kaskel, Abrams and Muhsin.

The Provider contends that the costs of interns and residents that are not included in its GME and IME payments should be paid pursuant to 42 C.F.R. §405.522, Interns' and residents' services

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[7] Intermediary Revised Final Position Paper at 8. See Provider's Post-Hearing Brief at 19-22.
[8] Intermediary Revised Final Position Paper at 10.
[9] Exhibit I-9.
[10] Provider's Post-Hearing Brief at 16.
[11] Provider's Post-Hearing Brief at 18.

not in approved teaching programs. The Intermediary does not dispute this argument but believes the Provider did not capture the data necessary to complete Worksheet D-2 of its cost report for this purpose. However, the Provider asserts that it does have all of the necessary information and this issue should be remanded to the Intermediary for resolution.[12]

Issue No. 3-Inn at University Village

In 1987 the Provider developed a hotel to be used to accommodate patients and their families, recruited physicians, and other individuals with business in the area. The hotel was named the Inn at University Village (Inn). During the subject cost reporting period, the Provider believed the Inn's operation was related to patient care and claimed $932,754 of Inn costs in its Medicare cost report. These costs include an operating loss of $278,917 and depreciation on buildings and equipment of $653,837.

Upon review, the Intermediary determined that the Inn's operation was not related to patient care and disallowed the Inn's costs for purposes of program reimbursement. The Provider accepted the Intermediary's position, but now believes the Inn's costs must be considered an investment loss which should be offset against its investment income ultimately used to calculate the Provider's allowable interest expense.

Program instructions at HCFA Pub.15-1 §1218.2 define Invested Funds as: "funds diverted to income producing activities which are not related to patient care." Moreover, program instructions at HCFA. Pub.15-1 §202.2.C state, in pertinent part:

> [i]f funds generated from patient care activities are invested in nonpatient care related activities, the provider's allowable interest expense is reduced (offset) by the provider's investment income in order to determine the amount of interest expense that is necessary and therefore allowable . . .
>
> Investment income for offset is the aggregate net amount realized from all investments of patient care funds in nonpatient care related activities and may include interest, dividends, operating profits and losses, and gains and losses on sale or disposition of investments. . . .
>
> Investment income resulting from investment of funds not generated from patient care activities is not subject to offset. In addition, if the funds invested in nonpatient care activities are borrowed, the interest expense is not allowable and the investment income is not subject to offset.

[12] Provider's Post-Hearing Brief at 24 and 36.

Based upon these rules, the Intermediary contends that the Inn's costs (loss from operations and depreciation) may not be offset against the Provider's investment income because the Inn was constructed with borrowed funds. The Intermediary refers to several documents submitted by the Provider indicating that $10,000,000 was borrowed from the Illinois Educational Facilities Authority (IEFA) to construct the Inn, and the fact that interest expense related to the borrowing was charged to the Inn's accounting records.[13]

The Provider contends that the sole basis for the Intermediary's position is its belief that the Inn was constructed with IEFA funds. However, the IEFA loan documents, as well as testimony elicited at the hearing, show that proceeds of the IEFA loan were used for allowable equipment purchases, and that these funds could not have been used to fund the Inn.[14]

FINDINGS OF FACT, CONCLUSIONS OF LAW, AND DISCUSSION:

The Board, after consideration of Medicare law and guidelines, parties' contentions, and evidence presented, finds and concludes as follows:

Issue No. 1-Disproportionate Share

Program Memorandum A-99-62 provides specific rules for hospitals such as the Provider that did not receive payment for the erroneous inclusion of general assistance days in their DSH calculation. For cost reports settled before October 15, 1999, a hospital could have its DSH reimbursement re-calculated to reflect the inclusion of its general assistance days if it filed a jurisdictionally proper appeal to the Board specifically appealing "the exclusion of these types of days." In addition, if a hospital's appeal was filed on or after October 15, 1999, its DSH reimbursement would be re-calculated if it had also appealed the exclusion of general assistance days prior to October 15, 1999 in previous cost reporting periods.

It is undisputed that the Provider did not precisely challenge the exclusion of "general assistance days" in the instant case. Instead, the Provider, in its position paper, challenged the exclusion of "all inpatient hospital days as directed by HCFA Ruling No. 97-2 dated February 27, 1997."[15] Since HCFA Ruling 97-2 specifically addresses the matter of Medicaid eligible days and does not speak to general assistance days in any manner, the Provider fails to meet this requirement.

However, the Provider does qualify for the hold harmless relief of Program Memorandum A-99-62. As discussed above, a provider may have its DSH reimbursement re-calculated with the inclusion of general assistance days if its appeal was filed on or after October 15, 1999, and the provider had appealed the exclusion of general assistance days in prior cost reporting periods.

Regarding the instant case, the Board finds that the Provider added the general assistance days issue to its existing appeal through the submission of a revised final brief filed with the Board on

[13] Intermediary's Revised Final Position Paper at 18.
[14] Provider's Post-Hearing Brief at 40. Exhibit P-58. Transcript (Tr.) at 59.
[15] Provider's Post-Hearing Brief at 5.

May 21, 2002. The Board finds that adding the general assistance days issue in this instance is equivalent to filing a jurisdictionally proper appeal. The Board believes that to interpret the memorandum's language any other way would permit disparate treatment of providers. That is, providers that filed appeals for the first time after the memorandum was issued would have hold harmless protection provided they had a history of challenging the exclusion of general assistance days. In contrast, a provider that had an appeal pending but added the issue would not be provided hold harmless protection even though it had the same history of claiming the exclusion.

The Board further believes its position is supported by the memorandum's language stating that: [y]ou are to continue paying the Medicare DSH adjustment reflecting the inclusion of general assistance . . . days for all open cost reports for cost reporting periods beginning before January 1, 2000, to any hospital that, before October 15, 1999, filed a jurisdictionally proper appeal to the PRRB specifically for this issue on *previously* settled cost reports." Clearly, the deciding factor in determining whether or not a provider qualifies for the hold harmless protection of Program Memorandum A-99-62 is whether or not the provider had a history of claiming the exclusion of general assistance days in prior period cost reports. The Board notes that there is no dispute that the Provider had a history of appealing the exclusion of general assistance days as the Provider appealed this issue in its 1989 and 1990 cost reporting periods (PRRB Case Nos. 92-1678 and 92-1717).

Finally, the Board disagrees with the Intermediary's argument that the Provider's 1989 and 1990 appeals have no application to the instant case because they were settled through an Administrative Resolution which made no payment to the Provider for general assistance days in its DSH determinations. The qualifying factor of Program Memorandum A-99-62 is a history of appealing the exclusion of general assistance days; whether or not payment was made for those days is not a requirement.

Issue No. 2- Graduate Medical Education

The Intermediary excluded a number of FTE residents from the Provider's GME and IME calculations because the residents participated in one of thirteen fellowship programs that had not been approved by a recognized approving organization (42 C.F.R. §413.86) or had not received approval at the time of the subject cost reporting period.[16] The Provider argues that each program meets the statutory definition of an "Approved Medical Residency Training Program" at 42 U.S.C.1395ww(h)(5)(A), in that each program counts toward certification in a specialty or subspecialty. The Provider also argues that, at a minimum, the FTE residents associated with eight (8) of the subject programs should be allowed because the programs were new and the ACGME did not have an approval process in place (although the programs were approved by other organizations), or because the programs received ACGME approval after the cost reporting period.[17]

[16] See chart at Provider's Post-Hearing Brief at 15.

[17] See chart at Provider's Post Hearing Brief at 19.

The regulations governing the approval of GME programs, including IME reimbursement, 42 C.F.R. §413.86 and 42 C.F.R. §412.118(g)(i)(.86), provide more detail than the statute on what constitutes an "approved" program. The Board concludes that the regulations are consistent with the statute; accordingly, the Provider's programs must comply with the approval requirements of the regulations. Therefore, in order for residents to be included in a provider's FTE count for the purpose of determining IME and GME reimbursement, the programs in which they participate must be approved by an organization listed in 42 C.F.R. §405.522(a), they must count towards certification in a specialty or subspecialty listed in the Directory of Residency Training Programs published by the American Medical Association, or they must have been approved by the ACGME. Residents associated with graduate programs approved by any other organization are not to be included in a provider's FTE count for IME and GME reimbursement purposes.

In addition, the regulations are clear that residents must be "enrolled" in an approved program to be included in a provider's FTE resident count. This means that a provider's programs must be approved at the time the provider is claiming reimbursement for its GME and IME costs, and approvals that are received in later periods cannot be applied retroactively.

Applying these rules to the thirteen GME programs at issue, the Board concludes that the FTE residents disallowed by the Intermediary are proper with one exception, which is the FTE residents associated with the Provider's neuroradiology program. The cost reporting period at issue ended June 30, 1991, and the Provider's neuroradiology program was approved by the ACGME on October 22, 1991. Therefore, the FTE residents should be included in the Provider's GME and IME reimbursement determinations because the ACGME approval would be based upon the program's conduct in the subject cost reporting period. The Board believes that any GME program must exist with participating residents before it can receive formal approval.

Additionally, the Board finds that neither party disputes the Provider's entitlement to have the costs of residents excluded from its GME and IME determinations for non-approved programs reimbursed through Worksheet D-2 of its Medicare cost report. Accordingly, the Provider must revise its cost report for this purpose and furnish all documentation required by the Intermediary to support its claim. The Provider understandably did not complete Worksheet D-2 as part of its initial cost report submission since it believed each resident would be included in its FTE counts.

The Intermediary also excluded or reduced certain FTE residents from the Provider's IME and GME determinations due to discrepancies with the Provider's documentation. These discrepancies and the Board's findings are as follows:

Dr. R. Lakshman – The Provider claimed .33 of an FTE for this resident for GME. The Intermediary reduced the FTE by 50 percent because the resident was not in an initial residency period. This adjustment is undisputed. However, the Intermediary then eliminated the FTE entirely because the resident's resume placed him at Loyola University Medical Center during the subject cost reporting period as opposed to being at the Provider's facility. The Provider argues, however, that the resident's rotation schedule shows that the resident was assigned to the

Provider's facility for 120 days, which justifies that .16 of an FTE be included in the Provider's GME determination. The Board agrees with the Provider. The pertinent rotation schedule (Exhibit I-13) places the resident at the Provider's facility for 120 days from November through April of the cost reporting period. The Board finds that a provider's rotation schedule is generally the most accurate documentation supporting the resident's assignments during the academic year, and is the document most frequently relied upon by intermediaries for the purpose of determining a hospital's FTE resident counts. The Provider is entitled to .16 of an FTE for its GME count.

Dr. H. Abusharif - The Intermediary disallowed the entire FTE for this resident for GME because the rotation schedule placed him at Christ Hospital during the cost reporting period and not at the Provider's facility (Exhibit I-14). While the Provider argues that certain other documentation shows that the resident worked at its facility for most of the cost reporting period (See e.g., Exhibit P-37), the Board disagrees. As discussed immediately above, the Board believes that a provider's rotation schedule is generally the most accurate documentation supporting a resident's assignments. In this instance, the rotation schedule places the resident at Christ Hospital during the subject cost reporting period. The Intermediary's disallowance is proper.

Dr. Soltes – The Intermediary disallowed an entire FTE for this resident for GME because the resident had not received certification from the Educational Commission for Foreign Medical Graduates (ECFMG) (Exhibits I-15 and I-8). The Provider argues that the resident did receive certification through the "fifth pathway" program by completing a year of civil services at the Mount Sinai School of Medicine.

According to the pertinent regulation, a resident that graduated from a foreign medical school is not required to have received certification from the ECFMG to be counted for GME. Rather, in order to be included in a provider's FTE count, 42 C.F.R §413.86(h) requires a foreign medical school graduate to have either passed FMGEMS, or "[b]efore July 1, 1986, received certification from, or passed an examination of, the Educational Committee for Foreign Medical Graduates." (emphasis added). Although a letter from the ECFMG to Dr. Soltes (Exhibit P-38) explains that the resident has not met all of the requirements for ECFMG certification, it also clearly states that the resident passed the ECFMG Examination of July/November 1983. The Board finds that the Provider is entitled to an FTE for Dr. Soltes, not because the resident received certification from the ECFMG, but because the resident had passed the ECFMG examination.

Drs. Wong and Myles – Initially, FTEs were denied for these residents because the Intermediary believed they participated in an unapproved program. However, the Intermediary later allowed the Provider 1.5 FTEs for GME based upon a certification statement from the program director explaining that the residents participated in an approved program in maternal/fetal medicine. However, the Intermediary still denied FTEs for IME because the Provider could not document

that on September 4, 1990, the day for counting residents for IME, that the residents did not work in a non-allowable area of the hospital.

The Board finds that the Provider is entitled to an FTE for each of these residents for the purpose of determining the Provider's adjustment for IME. The Intermediary furnished no explanation as to why it questioned the location in the Provider's facility where these residents worked on September 4, 1990. However, it is undisputed that the residents participated in a maternal/fetal medicine program, and testimony elicited at the hearing demonstrates that residents in this program would not have worked in either of the Provider's non-allowable areas, i.e., the Provider's psychiatry unit or rehabilitation unit.[18]

Drs. Kaskel and Abrams – The Intermediary denied the Provider an FTE for each of these residents because their rotation schedule showed that they were assigned to an allergy/immunology area on September 4, 1990, and because the Provider disclosed that another resident assigned to that area should be excluded from the IME count because he worked in a non-allowable outpatient department. (Exhibit I-17). The Intermediary argues that there is no proof that Drs. Kaskel and Abrams did not also work in that same non-allowable area on September 4, 1990, the day of the IME count.

The Board finds that the Provider is entitled to an FTE for each of these residents for the purpose of determining its adjustment for IME. The Intermediary's denial is based upon speculation. The best evidence available, which is the rotation schedule, shows the residents at the Provider's facility on the IME count date. The Provider also presented a letter from the Director of the Allergy & Immunology Fellowship Program indicating that residents participating in that program likely spend 70 percent of their time performing inpatient services, 20 percent performing outpatient services, and 10 percent in conferences (Exhibit P-41).

Dr. Muhsin – The Intermediary denied an FTE for this resident because he rotated through the Johnson R. Newman Rehabilitation Center (JRB) on September 4,1990, which the Intermediary believed to be a non-allowable area for the IME count. The Intermediary argues that the Provider could not submit evidence showing that the resident was not in this distinct part unit.

The Board finds that the Provider is entitled to an FTE for this resident. The Intermediary's denial is based upon speculation as opposed to substantive evidence. The rotation schedule places the resident at the Provider's facility on the IME count day, and testimony elicited at the hearing shows that the JRB also consisted of an acute care facility in September 1990.[19]

Issue No. 3-Inn at University Village

The Intermediary argues that the Provider's hotel, the Inn at University Village, was built with funds borrowed from IEFA. Accordingly, the Intermediary contends that the Inn's operating

[18] Exhibit P-39. Tr. At 219.
[19] Tr. at 221.

loss should not affect the Provider's program reimbursement. The Board majority finds that the Inn was built with funds generated from patient care activities. Accordingly, the Inn's operating loss is to be aggregated with the Provider's other investment proceeds ultimately used to determine the Provider's net allowable interest expense. HCFA. Pub.15-1 §202.2.C.

The Provider borrowed $10 million from IEFA at about the same time that construction began on the Inn. However, it is undisputed that the loan was approved and completed in order for the Provider to replenish or be reimbursed for specific equipment purchases it had made. The first paragraph of the Preliminary Statement of the Loan Agreement states that the Illinois authority is making a $10 million loan to the Provider "for the purpose of loaning to the Corporation [Provider] the amount necessary to enable the Corporation to finance, refinance and/or be reimbursed for all or a portion of the costs of completing the projects described in Exhibit B hereto (collectively, the "Project").[20] The Board majority finds that Exhibit B of the Loan Agreement describes administrative costs and equipment expenses associated with the Provider's medical facilities and not the Inn.

In addition, when the loan proceeds were received by the Provider they were deposited in the Provider's general operating account. At this point, the IEFA funds lost their character as loan proceeds and took on the character of the operating funds they were intended to replace.[21] Therefore, even though the timing of the loan and the construction of the Inn may have been coincidental, and even if the motivation for the loan may have been to maintain patient care funds as the Inn was being constructed, that motivation does not change the character of the funds as being generated from patient care operations.

The Intermediary believes its position is supported by certain findings and conclusions drawn from Provider documentation. The Board majority is not compelled by the Intermediary's conclusions but instead finds the Provider's evidence, which includes sworn testimony, persuasive. In part, the Intermediary relies upon a cash flow projection developed for the Inn in June 1985, which includes a sentence explaining that the document could be used in applying for a loan to finance the hotel. The Board majority finds this language to be standard, commonly used language in such planning documents, and not language indicative that funds were actually going to be borrowed to construct the Inn.[22]

The Intermediary also refers to an updated cash flow projection for the Inn dated May 19, 1987 and to an internal budget document (Departmental Budget Comparison) issued December 17, 1991, which both show loan interest being charged to the Inn's revenue and expense statements.[23] The Intermediary believes the interest expense shows that the IEFA loan was used to construct the Inn. However, the Provider explained that it uses an internal process to

[20] Attached at Exhibit P-58.
[21] Tr. at 119.
[22] Exhibit P-44.
[23] Exhibits P-43 and P-45.

determine profitability where an average interest rate is applied to the funds used for the Inn to account for interest lost on unavailable funds. The Provider's explanation is supported by the fact that interest on the IEFA loan amounted to approximately $355,000 for the subject cost reporting period, which is substantially different than the interest applied to the Inn in the Provider's budget documents.[24]

One piece of evidence prepared by the Provider's independent accounting firm appears at first to link the IEFA loan to the construction of the Inn.[25] In part, the document states:

> The 10mm [million] debt is considered to be a tax-exempt borrowing. However, the hotel built with these proceeds is not considered a qualifying asset.

However, this document goes on to explain that the IEFA loan was not used for the Inn but was used to reimburse costs associated with the hospital as required in the Loan Agreement.[26] The document continues:

> [t]he debt acquired was based on prior capital expenditures of qualifying assets as noted in AA & Co's [Arthur Andersen and Company's] review of the debt compliance. Thus, FASB 62 is not applicable and FASB 34 must be applied. FASB 34 states that the amt. [amount] to be capitalized is the interest rate applied to the average amount of accumulated expenditures during the period or a reasonable approximation which would not produce a material difference. Thus AA & Co will use the ave. [average] int. [interest] rate on all borrowings. . . . "

Finally, the Board majority finds that the conclusions reached by the Intermediary in an audit of the Provider's 1986 operations represent compelling evidence that the Provider did not borrow or use IEFA funds to build the Inn. Exhibit I-27 is an audit workpaper showing the results of the Intermediary's review of the Provider's 1986 funded depreciation account "to support the FYE 1988 10mm [IEFA] note." On page 4 of the exhibit the auditor states:

> NOTE Per uses statement at left, none of the $10M borrowing was used for the Inn. . . . However, the provider is booking all int [interest] and amort [amortization] relating to this loan to the Inn. . . .This appears reasonable due to the following:
>
> 1. The Inn cost $9.8M to build. The provider used general funds &/or funded depr [depreciation]

[24] Tr. at 69.
[25] Exhibit I-21
[26] Tr. at 77. See also Tr. at 57, Arthur Andersen & Company's compliance audit validating that the IEFA proceeds were used for equipment purchases in accordance with the Loan Agreement.

monies to finance the construction. As funds were being used for the Inn, these dollars were not available for capital asset additions.

2. After the Inn construction was paid for, the provider borrowed $10M to replenish funds used. This $10M was used primarily to reimburse funds for prior capital purchases (monies were tied up in the Inn at the time).

DECISION AND ORDER:

Issue No. 1-Disproportionate Share

The Provider qualifies for the hold-harmless provision of Memorandum A-99-62 and is therefore entitled to have its state-only general assistance days included in its DSH calculation. The Intermediary's denial of the Provider's request is reversed. This issue is remanded to the Intermediary to verify the number of state-only general assistance days to be included in the Provider's DSH formula and to recalculate the Provider's DSH payment with the inclusion of those days.

Issue No. 2- Graduate Medical Education

The Intermediary's adjustments disallowing FTE residents that participated in graduate programs that were not approved by a recognized approving body or not approved at the time of the subject cost reporting period are proper. This includes the FTE residents shown in the chart on pages 15 and 16 of the Provider's Post-Hearing Brief, with the exception of the FTE residents associated with the Provider's Neuroradiology program, which are allowable.

The Provider is entitled to .16 of an FTE resident for GME for Dr. R. Lakshman. The Intermediary's adjustment is reversed.

The Provider is not entitled to an FTE resident for GME for Dr. H. Abusharif. The Intermediary's adjustment is affirmed.

The Provider is entitled to an FTE resident for GME for Dr. Soltes. The Intermediary's adjustment is reversed.

The Provider is entitled to an FTE resident for IME for each of Drs. Wong and Myles. The Intermediary's adjustments are reversed.

The Provider is entitled to an FTE resident for IME for each of Drs. Kaskel and Abrams. The Intermediary's adjustments are reversed.

The Provider is entitled to an FTE resident for IME for Dr. Muhsin. The Intermediary's adjustment is reversed.

The Provider in entitled to have the costs of the disallowed residents reimbursed through Worksheet D-2 of its Medicare cost report in accordance with 42 C.F.R §405.523 (1990). This issue is remanded to the Intermediary. The Provider will complete Worksheet D-2 of its cost report and any other required or related forms and furnish the Intermediary with all documentation needed to support its claim.

Issue No. 3-Inn at University Village

The Provider did not use borrowed funds to build the Inn but instead used funds generated from patient care activities. Therefore, the Inn's operating loss, which includes its loss from operations in addition to depreciation on buildings and equipment, is to be aggregated with the Provider's other investment income and losses and offset against the Provider's interest expense. The Intermediary's adjustment disallowing the Inn's costs is reversed.

Board Members Participating:

Suzanne Cochran, Esq.
Gary B. Blodgett, D.D.S.
Martin W. Hoover, Jr., Esq.
Elaine Crews Powell, C.P.A., (Dissenting Opinion as to Issue No. 3)
Anjali Mulchandani-West

FOR THE BOARD:

DATE: November 18, 2005

Suzanne Cochran, Esq.
Chairman

Dissenting Opinion of Elaine Crews Powell as to Issue No. 3

Issue # 3 – Treatment of the Operating Loss on The Inn at University Village

The majority concluded that the Inn was constructed with funds generated from the Provider's patient care operations; therefore, the Inn was an investment, and the operating loss it incurred must be offset against the Provider's investment income. I dissent.

I find that the facts in this case do not support such a conclusion. The timing of the Illinois Educational Facilities Authority (IEFA) loan was anything but coincidental to the construction of the Inn. The Provider justified the $10 million borrowing by claiming to reimburse itself for capital expenditures that had been paid for from operations during the preceding 17 months. I find that this refunding of operating funds transaction was entered into for the specific purpose of securing the cash needed to build the Inn while technically meeting the restrictions on the use of IEFA loan funds. I believe that we must look behind the transaction in order to determine the motivation for the loan, not just what the Provider would like for us to accept as the "purpose" of the loan.

While the Provider's position on the costs associated with the Inn has evolved over time, the essence of its intent must not get lost in eloquent rhetoric. Clearly, the Provider is asking the Medicare program to subsidize the loss it incurred in operating the Inn. I find that the operation of the Inn was not related to patient care, that the funds were borrowed for its construction, and consequently, that all aspects of its operation are outside the Medicare cost report.

Even if the construction of the Inn was financed from the operating account and not with borrowed funds, the record shows that the Provider had more than enough readily available money in its funded depreciation account to purchase the capital assets it "reimbursed itself for" with the proceeds of the IEAF loan. This fact renders the IEAF loan unnecessary and any related interest expense unallowable. The Intermediary's adjustment should be affirmed.

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