PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2008-D45

PROVIDER -
Swedish American Hospital
Rockford, Illinois

Provider No.: 14-0228

vs.

INTERMEDIARY -
Mutual of Omaha Insurance Company
(n/k/a Wisconsin Physicians Service)

DATE OF HEARING -
April 30, 2007

Cost Reporting Periods Ended -
May 31, 1999; May 31, 2000; May 31, 2001;
May 31, 2002; May 31, 2003

CASE NOs.: 05-1891; 05-1887; 04-1831;
05-0731; 06-1938

INDEX

Page No.

ISSUE:

Whether the Intermediary's adjustments reducing the 1996 base year IME/GME FTE[1] count for osteopathic and allopathic medicine interns and residents and their effect on the May 31, 1999 through May 31, 2003 FTE counts are correct.

MEDICARE STATUTORY AND REGULATORY BACKGROUND:

This is a dispute over the amount of Medicare reimbursement due a provider of medical services.

The Medicare program was established to provide health insurance to the aged and disabled. 42 U.S.C. §§1395-1395cc. The Centers for Medicare and 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 administering the Medicare program. 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 the providers under Medicare law and under interpretive guidelines published by CMS. See, 42 U.S.C. §1395h, 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 issuance of the NPR. 42 U.S.C. §1395oo(a); 42 C.F.R. §405.1835. Other relevant law regulations and related documents are presented as follows.

The Balanced Budget Act of 1997 (BBA)

In 1997, Congress enacted the BBA Pub. L. No. 105-33. Among other things, the BBA changed the way in which FTE residents were counted for purposes of calculating the IME adjustment and GME payments for teaching hospitals.

The BBA capped the number of allopathic and osteopathic residents that a hospital could count for purposes of calculating the IME adjustment and GME payments. Specifically, the BBA provided that a hospital's total number of FTE residents in the fields of allopathic and osteopathic medicine in a hospital or nonhospital setting could not exceed the number of FTE residents with respect to the hospital's most recent cost reporting

[1] IME = Indirect Medical Education
GME = Graduate Medical Education
FTE = Full Time Equivalent

period ending on or before December 31, 1996 ("FTE Resident Cap"). BBA, §§4621(b)(1), 4623; 42 U.S.C. §1395ww(d)(5)(B), 1395ww(h)(4)(F). For the IME adjustment, the FTE resident cap applies to discharges occurring on or after October 1, 1997. Id. For GME payments, the FTE resident cap applies to cost reporting periods beginning on or after October 1, 1997. Id. Furthermore, the BBA provided the Secretary with rulemaking authority to implement the FTE residents caps.

August 29, 1997 Final Rule

In order to implement many of the BBA's provisions, the Secretary promulgated a series of regulations associated with the inpatient Prospective Payment System (PPS) final rules for FY 1998. The first regulatory provisions addressing FTE resident caps appeared in the August 29, 1997 hospital inpatient PPS final rule, as corrected by final rules dated September 8, 1997 and September 18, 1997 ("August 1997 Final Rule"). 62 Fed. Reg. 45966 (August 29, 1997); 62 Fed. Reg. 47237 (September 8, 1997); 62 Fed. Reg. 49049 (September 18, 1997).

For purposes of GME, the August 1997 Final Rule set forth the FTE resident cap at then 42 C.F.R. §413.86(g)(4), which stated, in part, the following:

> For purposes of determining direct graduate medical education payment, for cost reporting periods beginning on or after October 1, 1997, a hospital's unweighted FTE count for residents in allopathic and osteopathic medicine may not exceed the hospital's unweighted FTE count for these residents for the most recent cost reporting period ending on or before December 31, 1996.

Consistent with Section 4621(b)(1)of the BBA, the August 1997 Final Rule also added the FTE resident cap for IME at then 42 C.F.R. §412.105(f)(1)(iv), which read as follows:

> Effective for discharges occurring on or after October 1, 1997, the total number of full-time equivalent residents in the fields of allopathic and osteopathic medicine in either a hospital or nonhospital setting that meets the criteria listed in paragraph (f)(1)(ii) of this section may not exceed the number of such full-time equivalent residents in the hospital with respect to the hospital's most recent cost reporting period ending on or before December 31, 1996.

In addition, the August 1997 Final Rule, at then 42 C.F.R. §413.86(g)(6) and (7), established certain limited provisions under which a hospital could adjust its FTE resident cap for direct GME upward after establishing a new medical residency training program, including a new program located in a rural area. Id. Furthermore, in then 42 C.F.R. §413.86(g)(4), the August 1997 Final Rule also granted affiliated groups the ability to aggregate their FTEs for purposes of the FTE resident cap for direct GME, stating:

> Hospitals that are part of the same affiliated group may elect to apply the limit on an aggregate basis.

As permitted by the BBA, the Secretary also defined the term "affiliated group" in the August 1997 Final Rule at then 42 C.F.R. §413.86(b) as follows:

> *Affiliated group* means two or more hospitals located in the same geographic wage area (as that term is used under part 412 of this subchapter for the prospective payment system) in which individual residents work at each of the hospitals seeking to be treated as an affiliated group during the course of the approved program; or, if the hospitals are not located in the same geographic wage area, the hospitals are jointly listed as major participating institutions for one or more programs as that term is used in *Graduate Medical Education Directory, 1997-1998*.

May 12, 1998 Final Rule

In the May 12, 1998 hospital inpatient PPS Final Rule for FY 1998 ("May 1998 Final Rule"), the Secretary responded to comments on the direct GME and IME provisions of the August 1997 Final Rule. See, 63 Fed. Reg. 26318 (May 12, 1998). The Secretary also made various modifications to then 42 C.F.R. §413.86 for direct GME, including a modification to the definition of an "affiliated group" at then 42 C.F.R. §413.86(b), which read as follows:

> *Affiliated group* means-
> (1) Two or more hospitals located in the same urban or rural area (as those terms are defined in §412.62(f) of this subchapter) or in contiguous areas if individual residents work at each of the hospitals during the course of the program; or
>
> (2) If the hospitals are not located in the same or a contiguous urban or rural area, the hospitals are jointly listed -
>
> (i) As the sponsor, primary clinical site or major participating institution for one or more of the programs as these terms are used in *Graduate Medical Education Directory, 1997-1998*; or
>
> (ii) As the sponsor or under "affiliations and outside rotations" for one or more programs in operation in *Opportunities, Director of Osteopathic Postdoctoral Education Programs*.
>
> (3) The hospitals are under common ownership.

Id. at 26358.

In addition, the May 1998 Final Rule added then 42 C.F.R. §412.105(f)(1)(vi) for IME purposes, which stated the following with respect to affiliated groups:

> Hospitals that are part of the same affiliated group (as described in §413.86(b)) may elect to apply the limit at paragraph (f)(i)(iv) of this section on an aggregate basis.

Id. at 26357.

In the preamble to the May 1998 Final Rule, the Secretary stated that two or more hospitals must enter into an agreement to aggregate their FTEs as an affiliated group. The Secretary stated:

> Each agreement must also specify the adjustment to each respective hospital cap in the event the agreement terminates, dissolves or, if the agreement is for a specified time period, for residency training years and cost reporting periods subsequent to the period of the agreement for purposes of applying the FTE cap on aggregate basis. In the absence of an agreement on the FTE caps for each respective institution following the end of the agreement, each hospital's FTE cap will be the indirect and direct medical education FTE count from each hospital's cost reporting periods ending in 1996 and the cap will not be applied on an aggregate basis. The net effect of adjustments to each hospital's FTE cap for each agreement must total zero on a program basis, as provided for in the above example. That is, if the agreement involves two hospitals, any positive adjustment for one hospital must be offset by a negative adjustment for the other hospital of at least the same amount.

Id. at 26339-26340.

In the May 1998 Final Rule, the Secretary also addressed a scenario where a hospital began training additional residents after its cost reporting period ending during 1996 because another hospital closed or discontinued its teaching programs during the July 1996 through June 1997 residency year. With respect to that scenario, the Secretary stated the following:

> . . . we agree that, when a hospital takes on residents because another hospital closes or discontinues its program, a temporary adjustment to the [FTE resident] cap is appropriate and consistent with the base year system.

Id. at 26330.

However, no changes were made to the regulation in 1998 at then 42 C.F.R. §§413.86 or 412.105 for a hospital to adjust its FTE resident caps when it assumed additional residents due to another hospital closing or discontinuing its teaching program.

August 1, 2001 Final Rule

In the August 1, 2001 hospital inpatient PPS Final Rule for FY 2002 ("August 2001 Final Rule") the Secretary amended then 42 C.F.R. §413.86 to established provisions for a hospital to temporarily adjust its FTE resident cap when a hospital assumes the training of additional residents because another hospital closed its residency teaching program. 66 Fed. Reg. 39899 (August 1, 2001).

Specifically, the August 2001 Final Rule provided that, if a hospital that closes its residency training program agrees to temporarily reduce its FTE resident cap according to the criteria specified in then 42 C.F.R. §413.86(g)(8)(i)(B) and (g)(8)(iii)(B), another hospital could receive a temporary adjustment to its FTE resident cap for direct GME to reflect residents added because of the closure of the residency training program if the criteria at then 42 C.F.R. §413.86(g)(8) are met. The Secretary incorporated similar provisions, in the August 2001 Final Rule, for IME at then 42 C.F.R. §412.105(f)(1)(ix). The Secretary stated that the foregoing adjustment provisions would only be applicable to cost reporting periods (for direct GME) and discharges (for IME) beginning on or after October 1, 2001.

August 1, 2002 Final Rule

In the August 1, 2002 hospital inpatient PPS Final Rule for FY 2003 ("August 2002 Final Rule"), the Secretary sought to clarify the requirements for hospitals participating in an affiliated group. 67 Fed. Reg. 49982 (August 1, 2002). Specifically, the August 2002 Final Rule added a new definition of the term "affiliation agreement" at then 42 C.F.R. §413.86(b). Id. at 50119. In addition, the August 2002 Final Rule added provisions at then 42 C.F.R. §§413.86(g)(4)(iv) and 413.86(g)(7) to clarify the requirements for a hospital to receive a temporary adjustment to its FTE resident cap for direct GME through an affiliation agreement. Id. at 50120. The Secretary also incorporated similar provisions at then 42 C.F.R. §412.105(f)(1)(vi) for purposes of the FTE resident cap for IME. Id. at 50112.

In the August 2002 Final Rule, the Secretary also made a change in policy pertaining to FTE resident cap adjustments and the termination of affiliation agreements. In doing so, the Secretary cited a statement in the Preamble of the May 1998 Final Rule, which stated the following with respect to affiliation agreements:

> Each agreement must also specify the adjustment to each respective hospital cap in the event the agreement terminates, dissolves, or, if the agreement is for a specified time period, for residency training years and cost reporting periods subsequent to the period of the

> agreement for purposes of applying the FTE cap on an aggregate basis.

Id. at 50070.

The change in policy was in response to the susceptibility of current CMS policy to abuse in that a hospital that was part of an affiliated group could transfer its FTE caps to another hospital in the same affiliated group pursuant to an affiliation agreement and, upon termination of the affiliation agreement, permanently increase another hospital's FTE resident caps pursuant to the terms of the agreement's termination clause. In the August 2002 Final Rule, the Secretary articulated the reason for the policy, in part, as follows:

> . . . existing policy allows affiliated hospitals to redistribute their FTE caps (within the limits of the aggregate FTE caps) upon the termination of the affiliation agreement in order to enable hospitals by agreement to more closely reflect the realities of the residency rotational arrangement . . .

Id. at 50075.

However, in the August 2002 Final Rule, the Secretary opined that its policy change is consistent with statutory provisions addressing FTE resident caps and Congressional intent. Thus, the August 2002 Final Rule added language at then 42 C.F.R. §§413.86(g) and 412.105(f) specifying that when an affiliation agreement terminates, the FTE resident cap of each hospital in the affiliated group will revert back to the individual hospital's pre-affiliation FTE resident cap.

The Secretary's change in policy was applied prospectively to terminations of affiliation agreements that occurred on or after October 1, 2002.

Redistribution of Unused FTEs

While the Medicare program makes GME payments and IME adjustments taking into account a hospital's FTE resident caps, Congress recognized that some hospitals were training allopathic and osteopathic residents in excess of their FTE residents caps. Congress also recognize that other hospitals had reduced their resident counts to some level below their FTE resident caps. Therefore, when Congress enacted the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Medicare Moderization Act of 2003 or "MMA 2003"), Pub. L. 108-173. Section 422 of the MMA 2003 added Section 1886(h)(7) of the Act, which provided for the one-time redistribution of "unused" FTE resident positions in the fields of allopathic and osteopathic medicine.

In general, a hospital's "reference resident level" is its resident level for the most recent cost reporting period ending on or before September 30, 2002,[2] for which a cost report has been settled (or, if not, submitted). 42 U.S.C. §1395ww(h)(7)(A)(ii)(I). Specifically, Section 1886(h)(7)(A) provided for a hospital's FTE resident cap to be reduced if its reference resident level was less than the otherwise applicable resident limit (FTE resident cap). 42 U.S.C. §1395ww(h)(7)(A). The reduction was equal to 75 percent of the difference between the hospital's otherwise applicable FTE resident cap and its reference resident level. 42 U.S.C. §1395ww(h)(7)(A)(i)(I).

Section 1886(h)(7)(B) of the Act authorized the Secretary to increase the otherwise applicable FTE resident cap for certain qualifying hospitals for portions of cost eporting periods occurring on or after July 1, 2005, by a number not to exceed the estimated aggregate reduction in FTE resident caps for all hospitals under Section 1886(h)(7)(A). 42 U.S.C. §1395ww(h)(7)(B)(i). However, a single hospital could not receive an increase in its FTE resident caps of more than 25 FTEs. 42 U.S.C. §1395ww(h)(7)(B)(iv).

In determining which hospitals would receive FTE resident cap increases, Section 1886(h)(7)(B) directed the Secretary to: (i) take into account the demonstrated likelihood of a hospital filling the additional positions within the first 3 cost reporting periods beginning on or after July 1, 2005; and (ii) to distribute resident slots in an established priority order: first, to programs in hospitals located in rural areas; second, to hospitals located in urban areas that are not large urban areas; and third, to other hospitals in a State where there is no other residency training program for a particular specialty in the State. 42 U.S.C. §1395ww(h)(7)(B)(ii) and (iii).

To implement Section 422 of the MMA 2003, the Secretary promulgated regulations and CMS issued related guidance[3] providing that a hospital seeking additional FTEs as part of the redistribution was required to apply by December 15, 2004.[4] Otherwise, a hospital was precluded from obtaining additional FTEs as part of the one-time redistribution.

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Swedish American Hospital (Provider) was a 293-bed acute care hospital that included a 20-bed hospital-based psychiatric unit located in Rockford, Illinois. Mutual of Omaha (Intermediary) was the Provider's Medicare fiscal intermediary.

The Intermediary made final determinations (both in the initial NPRs and Revised NPRs (RNPRs) on the Provider's Medicare cost reports. The Intermediary adjusted the

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[2] Under certain circumstances and upon a timely request, a teaching hospital's cost reporting period that includes July 1, 2003 could be used for this determination. See, 42 U.S.C. §1395ww(h)(7)(A)(ii)(II).

[3] 69 Fed. Reg. 48916 (August 11, 2004); 69 Fed. Reg. 69536 (November 30, 2004); CMS Pub. 100-20, Transmittal No. 77 (April 30, 2004); CMS Pub. 100-20, Transmittal No. 87 (May 26, 2004); CMS Pub. 100-20, Transmittal No. 92 (July 2, 2004); CMS Pub. 100-20, Transmittal No. 127 (December 3, 2004).

[4] See, 69 Fed. Reg. 69536 (November 30, 2004); 69 Fed. Reg 49115-49116 (August 11, 2004) at Exhibit I-17. However, if a hospital's resident level was audited for purposes of Section 1886(h)(7)(A) of the Act, a hospital's application for additional FTEs had to be received by CMS on or before May 1, 2005.

IME/GME FTE cap to reflect the interns and residents FTEs at the hospital during the Provider's May 31, 1996 base year cost reporting period. The Exhibits designated below identify the audit adjustments and settled cost reports. The Provider filed timely requests for hearing before the Provider Reimbursement Review Board as indicated below:

FYE	Intermediary Determination Date and Type	Date Hearing Request Filed	GME/IME FTE Cap Audit Adjustment Numbers	Provider's Estimated Reimbursement Impact	Exhibit Number
5-31-99	5-13-05 (RNPR)	7-20-05	4	$355,303	P-44
5-31-00	5-16-05 (RNPR)	7-20-05	5 and 8	$603,149	P-45
5-31-01	5-16-05 (RNPR)	7-20-05	14 and 6	$964,314	P-46
5-31-02	5-20-05 (RNPR)	7-20-05	4 and 7	$806,944	P-47
5-31-03	3-13-06 (NPR)	7-10-06	24 and 36	$1,068,888	P-48

The Provider participated with the University of Illinois, College of Medicine at Rockford (University) in a Family Practice Residency Program (Program). An agreement between the Provider and University was in effect for the audit of the Provider's base year of May 31, 1996.[5] The Intermediary established a cap of 12.38 FTE residents for the IME program and 15.05 FTE residents for the GME program.[6] The Provider's resident rotation schedules for the May 31, 1996 fiscal year end at Exhibit P-49 pages 17 to 21 reflect this resident count.

During this same period of time, Saint Anthony Medical Center, another hospital located in Rockford, Illinois, similarly had an agreement with the University concerning the Family Practice Residency Program. The Intermediary audited Saint Anthony's FTE base year of September 30, 1996 and established a cap of 6.42 FTE residents for the IME program and 8.42 FTE residents for GME program.[7] The Provider's resident rotation schedules and IRIS reports for the September 30, 1996 fiscal year end[8] reflect this resident count. Saint Anthony did not claim any FTEs for training interns and residents after its September 30, 1996 cost

[5] See, Intermediary Exhibit I-1.
[6] See, Intermediary Exhibit I-2.
[7] See, Intermediary Exhibit I-3.
[8] See, Intermediary Exhibit I-20.

report. In addition, Saint Anthony is not listed as a participant in the Family Practice Residency Program in the ACGME Directory after the 1995-1996 academic year.[9]

Saint Anthony and the Provider did not have an affiliated group agreement. In June of 1996 Saint Anthony Medical Center withdrew from the residency program. The residents that were a part of the Saint Anthony program were absorbed by the Provider's residency program. It is these Saint Anthony residents and their related FTE cap that is at the core of this appeal.

The Provider was represented by Charles F. MacKelvie, Esquire, of MacKelvie & Associates, P.C. The Intermediary was represented by Terry Gouger, C.P.A., of Mutual of Omaha Insurance Company.

PROVIDER'S CONTENTIONS:

The Provider contends that its higher FTE resident caps reflected the realities of the residency rotation arrangement the Provider assumed during the program's 1996-1997 academic year. The Provider became contractually bound to assume the rotations during its FY 1996 cost reporting period. The Intermediary audited and settled FY 1998 through 2002 cost reports allowing the higher FTE resident caps. The Provider's higher FTE resident caps also fell within the confines of the national FTE resident cap contemplated by Congress in the BBA. Therefore, the Intermediary's change in position reducing the FTE residents caps and counts are inconsistent with Congressional intent, contravene the BBA, and should be reversed.

Furthermore, the Provider argues that the Intermediary should be estopped from changing its position and reducing Swedish Hospital's count of FTE residents for FYs 1999-2003. In 1998, the Intermediary knew the facts associated with the Provider's absorbing St. Anthony's residents and clearly intended for the Provider to act on its guidance. In fact, being uncertain about Medicare policy on FTE resident cap adjustments, the Provider sought the Intermediary's guidance while preparing the 1998 cost report. The Provider explained to the Intermediary the factual scenario associated with Swedish Hospital's assumption of all of the program's resident rotations, and proposed increasing its FTE resident caps to reflect the resident rotations it assumed in 1996. The Intermediary agreed with the Provider's proposal and advised it to file its cost reports in accordance with that proposal, indicating that the Intermediary would make any adjustments to the FTE resident caps through the cost report audit process, if necessary.

Throughout FYs 1998-2002, the Intermediary's auditors also clearly understood that the Provider's FTE resident caps had been increased to reflect the rotation arrangement that the Provider assumed when it took over the program in 1996. Furthermore, as the assigned fiscal intermediary for both the Provider and St. Anthony, the Intermediary also knew that St. Anthony withdrew from the program in 1996, and that the Provider had taken over all of the program's resident rotations at that time.

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[9] See, Intermediary Exhibit I-26.

The Provider relied on the Intermediary's guidance and repeated actions in completing and filing its 1998-2003 cost reports and in decisions regarding the amount of program costs and expenses to incur for FYs 1998-2003. Furthermore, such reliance has caused the Provider substantial injury in the form of reduced Medicare payments for IME and GME in FYs 1999-2003 and a substantial amount of incurred program cost and expenses that the Intermediary now claims are non-reimbursable and which the hospital is unable to recoup from any other source. In fact, had it known that the Intermediary's guidance and actions were inconsistent with Medicare policy, the Provider would have reduced its financial support to the program, or possibly abandoned the program altogether in 1998-2003.

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that there is no regulation that would allow St. Anthony's FTE cap to be transferred to the Provider regardless of any agreements between the Provider and St. Anthony. The regulatory provisions at 42 C.F.R. §413.86(g)(4) became effective October 1, 1997, which is after the June 30, 1996 closure of St. Anthony and it cannot be applied retroactively.

The Provider could not have been part of an affiliated group since residents did not rotate to other hospitals after October 1, 1997. In situations where hospitals no longer have a relationship for training residents and do not meet the criteria for being a member of an affiliated group, CMS allows the FTE cap based on 1996 FTE counts. When a relationship terminated, the FTE caps are not transferred but revert back to the hospital's 1996 FTE counts.

The Provider did not ask to be part of an affiliated group as required by the May 12, 1998 Federal Register. Since St. Anthony did not terminate from the Medicare Program, it could have reinstated its residency training program or affiliated with other hospitals. Furthermore, the regulation that addresses the temporary transfer of FTE caps, 42 C.F.R. §413.86(g)(8)(ii)(B), became effective October 1, 2001; therefore, it does not apply to this case. In addition, the Provider never requested a temporary adjustment of its FTE resident caps.

The Provider's allegations that the Intermediary had advised it that the proposed arrangement was allowable in principle is unfounded. The Provider has no evidence that: (1) the Intermediary granted explicit approval for a "composite base year FTE count;" (2) a lack of an adjustment in prior periods can be construed to mean explicit approval; or (3) the Intermediary purposely waited until the time frame had elapsed for the Provider to request a redistribution of additional GME FTEs.

FINDINGS OF FACT, CONCLUSION OF LAW AND DISCUSSION:

After considering the Medicare law and guidelines, parties' contentions and evidence submitted, the Board finds and concludes that the Intermediary properly reduced the Provider's 1996 base year FTE resident IME/GME counts for osteopathic and allopathic medicine.

In examining the facts in this case, the Board finds that the Provider did not meet any of the various requirements of the Medicare regulations that would have allowed it to include St. Anthony's IME/GME FTE cap and count in its counts.

The August 1997 Final Rule provided for affiliation agreements among parties and the related allocation of FTEs to the members of the affiliated group. The Board notes that an affiliation agreement was signed by the parties (Swedish, St. Anthony and the Board of Trustees of the University of Illinois).[10] It was executed on March 15, 1991. However, on February 13, 1995, the administrator/CEO of St. Anthony Medical Center notified the University of Illinois, College of Medicine at Rockford,[11] that its participation in the family residency program would cease on or about June 30, 1996. This notice was in compliance with the terms of the affiliation agreement. A new affiliation agreement[12] became effective July 1, 1996 and was only between the University and Swedish American Health System. This agreement makes no allowance for another hospital's residents or caps to be shared. Therefore, in reviewing these documents as well as the record as a whole, the Board finds no evidence that would allow St. Anthony's IME/GME FTE cap and count to be included with Swedish Hospital's count.

The Provider alleges that the Intermediary misled it into believing that St. Anthony's FTE cap count could be included in the Provider's count. Even if this allegation were true, the Board's authority is limited to the application of the Medicare regulations as they relate to evidence presented by the parties.

The Board observes that the Provider has argued that it was injured by the Intermediary's inappropriate guidance, and as a result, it missed an opportunity to receive additional FTEs as part of the one-time redistribution of unused FTEs under section 422 of the MMA of 2003. As a result of the Intermediary's guidance, the Provider contends that it missed the December 15, 2004 regulatory deadline that would allowed it to apply for redistribution of unused IME/GME residents and increase its cap. The Board is sympathetic to the Provider's plight. However, the FTE redistribution would only apply in 2006 and thereafter, and these years are not before the Board.

Although the Provider presented a preponderance of evidence to document its takeover of St. Anthony's residency training program and these documents were informative and show the history and relationships of the parties, the Board finds none of these relevant. The Board is bound by the Medicare law relative to how the FTE resident count for the 1996 base year should be reflected and reported for each hospital. The Board finds that Swedish Hospital's FTE resident cap should only reflect its 1996 FTE resident count, and that St. Anthony's 1996 FTE count remains assigned to it upon the termination of its relationship with Swedish and the University on June 30, 1996.

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[10] See, Provider Exhibit 1.
[11] See, Provider Exhibit 29.
[12] See, Provider Exhibit 38.

DECISION AND ORDER:

The Intermediary properly applied and used the 1996 base year IME/GME FTE cap for Swedish Hospital only. The Intermediary's adjustments are affirmed.

BOARD MEMBERS PARTICIPATING:

Suzanne Cochran, Esquire
Elaine Crews Powell, C.P.A.
Yvette C. Hayes
Michael D. Richards, C.P.A.

FOR THE BOARD:

Suzanne Cochran, Esquire
Chairperson

DATE: September 30, 2008