PROVIDER REIMBURSEMENT REVIEW BOARD
HEARING DECISION

ON-THE-RECORD
97-D1

PROVIDER -
Little Company of Mary Hospital
and Health Care Centers
Evergreen Park, Illinois

Provider No. 14-0179

vs.

INTERMEDIARY -
Blue Cross and Blue Shield Association/
Blue Cross and Blue Shield of Illinois

DATE OF HEARING-
August 27, 1997

Cost Reporting Period Ended -
June 30, 1989

CASE NO. 92-1498

INDEX

ISSUES:

1. Was the Intermediary's necessity of borrowing determination with regard to the Provider's Illinois Health Facility Authority ("IHFA") loan proper?

2. Did the Intermediary properly include the Provider's neonatal unit beds and days in the indirect medical education ("IME") calculation and graduate medical education ("GME") patient load calculation for the fiscal year ended June 30, 1989?

3. Did the Intermediary properly allocate the Provider's investment income consistent with the allocation of interest expense?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Little Company of Mary Hospital and Health Care Centers ("Provider") is an acute care, non-profit hospital located in Evergreen Park, Illinois. Blue Cross and Blue Shield Association/Blue Cross and Blue Shield of Illinois is the Provider's fiscal intermediary ("Intermediary"). For the fiscal year ended June 30, 1989, the Provider filed its Medicare cost report with the Intermediary which resulted in the issuance of a Notice of Program Reimbursement ("NPR") on September 28, 1991.[1] The NPR effected various adjustments to costs claimed by the Provider which included determinations relating to the above-stated issues.[2]

On March 15, 1992, the Provider appealed the Intermediary's adjustments to the Provider Reimbursement Review Board ("Board") and has met jurisdictional requirements of the regulations at 42 C.F.R. §§ 405.1835-.1841. The estimated amount of Medicare reimbursement in dispute for the remaining issues in this appeal is approximately $80,000. The Provider was represented by Kurt L. Hudson, Esquire, of Hinshaw & Culbertson, and the Intermediary's representative was James R. Grimes, Esquire, of the Blue Cross and Blue Shield Association.

Issue 1 - Necessary Borrowing:

During the cost reporting period ended June 30, 1989, the Provider obtained a loan in the amount of $3,029,012 from the Illinois Health Facility Authority for which it claimed interest expense as a capital-related cost. Upon audit, the Intermediary disallowed the interest expense based on its determination that the purpose of the loan was to reimburse the Provider for previous expenditures and not for the acquisition of capital assets. In the interest of

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[1] Provider Exhibit C.

[2] Except for the above-stated issues, all other issues previously appealed by the Provider have been administratively resolved or withdrawn from this case.

facilitating the presentation of this issue before the Board as a hearing on the written record, the parties submitted a "Stipulation and Statement of Uncontested Fact" which included a separate set of exhibits pertaining to the following joint stipulations:

1. The issue to be determined by the Board based on the evidence in the record is:

   Was the Intermediary's necessity of borrowing determination with regard to the Provider's Illinois Health Facility Authority loan proper?

2. On March 5, 1985, the Board of Directors of Little Company of Mary Hospital and Health Care Centers approved a proposal presented by Dr. Shirazi to acquire a linear accelerator. Exhibit 1.

3. The certificate of need (C.O.N.) for this project was filed with the Illinois Health Facilities Board in September, 1985 and was approved by the planning board on December 5, 1985. Exhibit 2.

4. The estimated cost for the project was $1,687,164 and the finalized audited cost was $1,588,441. Exhibit 2, page 12 and Exhibit 3, page 1. The Provider also expended another $1,156,430 for expenditures not included within the C.O.N.. Exhibit 3 pp. 5 and 6. Also, see auditor's workpaper for asset additions and depreciation.

5. The Illinois Health Facilities Planning Board determined that the project completion date was September 10, 1990. Exhibit 3, p. 1.

6. The Provider originally planned to finance the project via a leasing transaction (Exhibit 2, pages 3 through 9), but had difficulty clarifying the financing package for inclusion in the C.O.N. application. Exhibit 2, p. 5.

7. From 1985 through 1988 the Provider expended $3,029,012 from its operating funds for the linear accelerator project. (Exhibit 6, p.4). The Provider signed contracts and made expenditures on the linear accelerator project during the period September 1985 though September 1988. Exhibit 4. The following are examples:

Exhibit	Date	Amount	
Ex. 4, p. 20	9/1/87	$602,672	Construction Contract
Ex. 4, p.6	4/14/88	30,002	Interior Furnishings Contract
Ex. 4, p.2	7/22/88	88,225	Insurance Contract
Ex. 4, p. 32	9/29/88	31,500	Furnishings
Ex. 3, p. 16	9/26/85	891,821	Equipment
Ex. 3, p. 7	12/4/87	553,758	Relocation of Radiation Department

8. Prior to C.O.N. completion date of September 10, 1990, the Provider's Board of Directors approved the permanent financing of the linear accelerator project through the Illinois Health Facilities Authority (IHFA) for $3,000,000. Exhibit 1, p. 9.

9. The Provider submitted a request for financing to the IHFA to finance the linear accelerator project and the loan agreement was signed on December 8, 1988. (Exhibit 5). The IHFA provided the funds via the issue of tax exempt bonds ("the 1988 bond issue").

10. The loan proceeds of $3,029,023 were received by the Provider and deposited into its funded depreciation account (Exhibit 6, Medicare auditor's workpapers). A few months later (May 31, 1989) $3,100,000 in funds were transferred from the funded depreciation account to an operations funds account because the funds had been expended from operating funds. Exhibit 7. The funds were later used for the cogenerator project which totaled $3,200,000. Exhibit 1, p. 9 and Exhibit 2, p. 2.

11. The permanent loan financing agreement and issuance of bonds occurred before the official C.O.N. project completion date, but after actual expenditures had been made by the Provider for the project. Exhibit 5, Exhibit 2, pp. 2-23, and Exhibit 4.

12. Because the signing of the loan agreement and issuance of bonds were subsequent to the dated expenditures, the loan agreement provided that the Provider is being reimbursed with the loan for its expenditures for the project. Exhibit 5, pp. 32 and 33.

13. The linear accelerator project was capitalized by the Provider in October, 1988. Exhibit 5, p.32, and Exhibit 6, p. 4.

14. The intermediary did not perform an analysis of the Provider's funded depreciation account with regard to funded depreciation availability, and the sole issue in this case

concerns whether the Provider's expenditures from its operating funds before the receipt of permanent financing renders the borrowing unnecessary to the extent of those expenditures.

PROVIDER'S CONTENTIONS:

The Provider contends that the Intermediary's adjustment to interest expense is inconsistent with the regulation at 42 C.F.R. § 413.153 and section 226 of the Provider Reimbursement Manual ("HCFA Pub. 15-1"). Pursuant to 42 C.F.R. § 413.153, interest expense is an allowable "pass through" cost if it is necessary and proper and related to a capital indebtedness. The Provider asserts that, during the years of 1984, 1986 and 1988, it had various ongoing IHFA loans and capital expenditures which pertained to capital projects and commitments approved by its Board of Directors. In 1984, the Provider obtained its first IHFA loan in the amount of $3,069,044 to finance various radiography capital project. This loan was amended and revised in 1986, and another IHFA loan was secured in 1988 to provide permanent financing for a linear accelerator. The Provider further points out that the project was first approved by the state planning agency on December 5, 1985. During the period of 1985 through 1988, the Provider expended $3,029,023 for a linear accelerator, nuclear medicine department relocation and remodeling, and a ventilator project.

The Provider acknowledges that it paid for the expenditures associated with the project from its operating funds, and that the project was not capitalized until October of 1988. The permanent financing secured by the issuance of IHFA bonds was obtained in December of 1988 with the loan proceeds being deposited into the Provider's funded depreciation account. The Provider states that the funds were transferred from the funded depreciation account a few months later and placed into an operating account. It is the Provider's position that the 1988 IHFA loan was for permanent financing, and that the loan proceeds were used to reimburse the Provider's operating fund for interim financing during the construction period. The Provider argues that, under 42 C.F.R. § 413.153 and HCFA Pub. 15-1 § 226, funded depreciation is considered committed if there is evidence of signed contracts for the various committed projects. However, this requirement only applies where the projects are coordinated by a general contractor pursuant to a signed contract. In the instant case, the Provider functioned as its own general contractor through its construction department and initially paid for the construction in progress from its operating funds. When the permanent loan proceeds were received for the project, the funds were deposited into the funded depreciation account and later transferred back to the operations account.

The Provider contends that, since it acted as its own general contractor, it was required to use its own funds as interim financing rather than securing such funds from a bank. The Provider argues that banks are unwilling to provide interim financing on capital projects unless independent or outside general contractors are utilized on the projects. Accordingly, operating funds were utilized as initial financing, and the IHFA loan agreement provided for permanent financing and reimbursement to the Provider because it had already made expenditures for the project from its own funds during the 1985-1988 construction period.

Under such circumstances, the Intermediary's inappropriate adjustment should be reversed because it is not supported by Medicare law and regulations and the facts in this case.

The Provider asserts that the Intermediary's adjustment is inconsistent with Medicare regulations and what is the usual and customary practice within the tax exempt bond financing industry. For a variety of reasons, it is usual and customary practice for bonds to be issued to reimburse providers for expenditures already made. In support of this contention, the Provider refers to an affidavit of an attorney who has twenty two years of public financing experience.[3] In his affidavit, the attorney states that, because this type of financing is with tax-exempt bonds, the Internal Revenue Service and the borrowers want to be sure of the interest rate and the amount needed before the bonds are issued to avoid over issuance and negative arbitrage. Due to the complexity of issuing bonds, interim financing during construction is not uncommon, and borrowers routinely finance projects from their operations and bonds are later issued to provide permanent financing to reimburse the borrower for these expenditures. Accordingly, the Provider concludes that the borrowing was necessary and the interest expense is an allowable cost under 42 C.F.R. §§ 413.5 and 413.153. Since these regulations provide for the reimbursement of costs which are usual and customary, permanent financing of interim construction financing costs are allowable under the Medicare program.

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that it properly disallowed the interest expense related to the IHFA loan because the purpose of the loan was to reimburse the Provider for previous capital expenditures. The loan agreement states that the purpose of the borrowing was to reimburse the Provider for capital expenditures of $3,029,023 made during the period of June 1, 1985 to October 31, 1988.[4] Since the purpose of the loan was to reimburse the Provider for previous expenditures, the Intermediary concludes that it properly disallowed the interest expense as unnecessary because the loan was not for the acquisition of capital equipment.

Issue 2 - Neonatal Unit:[5]

In conjunction with an affiliation agreement with the University of Chicago, the Provider participated in a GME/Medical Residency Program pursuant to the regulations at 42 C.F.R. § 413.86, which govern the allowability of medical education activities under the Medicare program. In computing the IME adjustment and GME costs for its fiscal year ended June 30, 1989, the Provider excluded nine neonatal unit beds and the associated bed days from the

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[3] Provider Exhibit WW.

[4] Provider Exhibit W - Page 10 and Exhibit A of Project Loan Agreement.

[5] The Provider withdrew its appeal with respect to the observation unit based on an administrative resolution with the Intermediary.

IME and GME calculation. Upon audit, the Intermediary determined that the neonatal beds and days should be included in the calculations under the regulatory provisions of 42 C.F.R. § 413.53.

PROVIDER'S CONTENTIONS:

The Provider contends that the Intermediary's adjustments are inappropriate and inconsistent with the regulation at 42 C.F.R. § 412.118(b) and the manual provisions set forth in HCFA Pub. 15-1 §§ 2405.3 and 2202.7. With respect to the IME adjustment, the Provider contends that the regulation specifically provides for the exclusion of neonatal beds as follows:

> [f]or purposes of this section, the number of beds in a hospital is determined by counting the number of available bed days during the cost reporting period, not including beds assigned to newborns, custodial care, and excluded distinct part hospital units, . . .

42 C.F.R. § 412.118(b).

The manual provision at HCFA Pub. 15-1 § 2405.3G, which was published August 25, 1988, states the following:

> a bed is defined for this purpose as an adult or pediatric bed (exclusive of beds assigned to newborns which are not in intensive care areas, custodial beds and beds in excluded units) maintained for lodging inpatients, including beds in intensive care units, coronary care units, neonatal intensive care units, and other special care inpatient hospital units.

HCFA Pub. 15-1 § 2405.3G (emphasis added).

The Provider asserts that the regulation clearly excludes beds assigned to newborns and does not specifically include neonatal care unit beds. As to the manual provision, the Provider notes that this section of the manual was published after the start of the cost reporting period at issue and, thus, its retroactive application would be improper, arbitrary and capricious.[6] The Provider further argues that the manual provision should be considered invalid because it is inconsistent and conflicts with 42 C.F.R. § 412.118(b) which is clear and unambiguous on its face. Since neonatal beds are assigned to newborns, they meet the plain meaning of the regulation and should be excluded from the IME calculation.

The Provider is aware of the U.S. Court of Appeals' decision in Sioux Valley Hospital v. Shalala, 29 F. 3rd, 628 (8th Cir. 1994) (unpublished decision table), wherein the court found the Secretary's interpretation of 42 C.F.R. § 412.118(b) was reasonable in requiring the

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[6] See Bowen v. Georgetown University Hospital, 488 U.S. 204 (1988).

inclusion of neonatal intensive care beds in the IME calculation. However, since the Provider is not located within the 8th Circuits's jurisdiction, the Provider avers that the above decision is not applicable in the instant case. Additionally, the Provider believes that the Court's decision misinterprets the Secretary's longstanding policy with regard to counting newborn beds and bassinets and their relationship to routine costs and special care unit costs. The Provider believes that with a well developed record on this matter, the U.S. Court of Appeals for the 7th Circuit (which includes the State of Illinois where the Provider is located) would reach a different decision on this issue than the one rendered by the 8th Circuit.

The Provider further argues that its neonatal unit beds should be excluded from the IME calculation because it is not an intensive care type unit within the meaning of 42 C.F.R. § 413.53(d) and HCFA Pub. 15-1 § 2202.7. Under the Medicare program's instructions, a special care unit must have a nurse-to-patient ratio of one nurse to two patients, highly specialized equipment and 24 hour continuous registered nurse care. The Provider asserts that its neonatal unit does not meet the above requirements. In the State of Illinois, there are three levels that characterize levels of baby care. Level 1 is the normal nursery; Level 2 is an intermediate unit; and Level 3 is a neonatal intensive care unit.[7] The State of Illinois has certified the Provider's neonatal unit as Level 2, or intermediate care. Since its neonatal unit is not a Level 3 unit, the Provider transfers babies in need of the highest level of intensive care to the University of Chicago Hospital which has a true Level 3 neonatal unit. The Provider states that a Level 3 neonatal unit would meet the Medicare program's definition of an intensive care type unit, not a Level 2. Because its neonatal unit is in reality similar to a "step down unit" or "intermediate care unit," the Provider explains that the level of care is higher than in a nursery, but not as intense as an intensive care unit or Level 3. It has been the Medicare program's longstanding policy that "step down" or "intermediate care" units are included in routine costs. Accordingly, it is the Provider's position that, if its neonatal intensive care unit does not meet the definition of a neonatal intensive care unit, it should be considered routine care by the Medicare program and reimbursed as part of the nursery and included with the nursery beds.

The Provider further argues that the regulation at 42 C.F.R. § 413.53(d) states that a unit must furnish services to critically ill patients to be considered an intensive care type unit. As such the unit furnishes services in life-threatening situations and provides a level of care comparable to that which is furnished in intensive care. The regulation also requires the unit to meet the following conditions:

1. The unit must be in a hospital.

2. The unit must be physically and identifiably separate from general routine care patient care areas, including subintensive or intermediate care units, and ancillary service areas.

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[7] Provider Exhibit T.

The Provider contends that its neonatal unit does not meet the second requirement because it is combined with an intermediate care unit. Also, when the neonatal unit is compared to other intensive care units within the Provider, the charges per patient day, hours per day and average costs per patient day for the unit is somewhere between the other intensive care type units and the nursery.[8] The Provider believes this data substantially indicates that the neonatal unit is an intermediate care unit that does not rise to the level of care within its other intensive care type units and, thus, the costs and charges of its neonatal unit should be combined with the nursery under routine care. In support of this position, the Provider cites various court decisions including the U.S. Court of Appeals for the 7th Circuit in St. Elizabeth Hospital, Inc. v. Bowen, 797 F. 2d 449 (7th Cir. 1986), ("St. Elizabeth")wherein the Court held that Medicare special care units must provide care "of the same kind" as that provided by a provider's intensive care or coronary care unit. If a unit does not provide the same level of care, it is not a Medicare special care unit and the costs and days must be combined with the routine/nursery care area.

In addition, the Provider argues that the classification of the neonatal unit's beds also applies to the calculation of GME costs for the years in contention. In calculating GME payments under the Medicare program, the amount of reimbursement is determined by multiplying the approved GME amount by the Medicare patient load (Medicare inpatient days to total inpatient days). Since nursery days are excluded from the Medicare patient ratio, the classification of the neonatal unit as a nursery would decrease the denominator in the ratio and, thus, increase the ratio and reimbursement amount. Inasmuch as the Provider's neonatal unit is not an intensive care type unit and does not meet the Medicare program's requirements for a special care unit as defined in HCFA Pub. 15-1 § 2202.7, the days associated with the unit should be included with nursery days, which are in turn excluded from the GME patient load calculation.

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that the Provider's neonatal intensive care beds should be included in the IME calculation and should not be classified as nursery beds. In support of this position, the Intermediary cites two decisions rendered by the Administrator of the Health Care Financing Administration ("HCFA") wherein the Administrator ruled contrary to the Provider's position in the instant case.[9] In reversing the Board's decision in Sioux Valley ,

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[8] See Provider Exhibit U.

[9] Sioux Valley Hospital v. Blue Cross and Blue Shield Association/Blue Cross and Blue Shield of Iowa, PRRB Dec. No. 92-D53, August 26, 1992, Medicare & Medicaid Guide (CCH) ¶ 40,747, rev'd by HCFA Admin., October 26, 1992, Medicare & Medicaid Guide (CCH) ¶ 41,044, aff'd sub. nom. Sioux Valley Hospital v. Sullivan, Civ. No. 92-4200 (D.S.D. October 23, 1993) (unpublished), aff'd Sioux Valley Hospital v. Shalala, 29 F. 3d 628 (8th Cir. 1994) (unpublished decision table) ("Sioux

which was upheld by the U.S. Court of Appeals, the Administrator's findings included the following:

> [t]he Administrator finds that HCFA's method of counting beds was not modified by the amendment in 1985 of 42 C.F.R. § 412.118(b). As amended, the IME regulation reflects the methodology HCFA has historically used to determine the number of beds. Contrary to the Board's conclusion, this regulation does not "clearly exclude all beds assigned to newborns, regardless of whether the newborn beds are located in a routine or an intensive care unit." The reference to "newborn" in the regulation can reasonably be interpreted to exclude only newborn bassinets receiving routine care. Further, the language of the regulation permits an interpretation that neonatal intensive care beds are properly counted as ICU beds. Accordingly, the Intermediary's adjustment in this case, which included the Provider's ICN beds in the determination of the resident-to-bed ratio portion of the IME cost calculation, was proper.

The Intermediary further notes that the Administrator reached the same decision in Humana Hospital finding as follows:

> [a]s early as 1976, however, a general methodology to determine the bed count had been included in guidelines issued by HCFA. PRM section 2510.5A, issued to establish bed sized categories for purposes of applying the cost limits under section 223 of the Social Security Amendments of 1972, excludes newborn beds but specifically includes beds in intensive care units and other special care inpatient hospital units. Further, PRM section 2202.7A, issued in 1977, describes the composition of a special care unit, and includes intensive care units in that definition. Moreover, this section of the PRM specifically notes that bed days in neonatal units which qualify as special care units are to be considered intensive care days rather than nursery days. Finally, PRM section 2405.3G, issued in 1988, specifically excludes beds "assigned to newborns which are not in intensive care areas . . ." from the count of available beds, noting that "newborn bassinets are not counted." Thus, this section incorporates into a single section existing policy setting forth the method for counting beds which had previously been expressed in several sections.
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> The Administrator finds that HCFA's definition of available beds was not modified by the amendment in 1984 of 42 C.F.R. § 412.118(b). As amended,

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Valley"); Humana Hospital University v. Blue Cross and Blue Shield Association/Blue Cross and Blue Shield of Kentucky, PRRB Dec. No. 95-D15, January 4, 1995, Medicare & Medicaid Guide (CCH) ¶ 43,021, rev'd by HCFA Admin., February 21, 1995, Medicare & Medicaid Guide (CCH) ¶ 43,140, ("Humana Hospital").

> the IME regulation reflects the methodology HCFA has historically used to determine the number of beds . . .

Id.

The Intermediary also refers to the manual provisions of HCFA Pub. 15-1 § 2405.3G which clarifies the definition of beds to be used in the IME calculation. The manual provision was revised in 1988 with the issuance of Transmittal No. 345, which established an effective date of August 25, 1988. The Intermediary cites the following pertinent part of the manual in support of its position:

> G. Bed Size. A bed is defined for this purpose as an adult or pediatric bed (exclusive of beds assigned to newborns which are not in intensive care areas, custodial beds and beds in excluded units) maintained for lodging inpatients, including beds in intensive care units, coronary care units, neonatal intensive care units, and other special care inpatient hospital units.

HCFA Pub. 15-1 § 2405.3G (emphasis added).

In response to the Provider's claim that its neonatal unit is not an intensive care type unit, the Intermediary advises that the Provider has consistently reported its neonatal unit as a special care unit in its as-filed Medicare cost reports. The Intermediary has reviewed and accepted this classification for the year under appeal and preceding years, and has made no adjustments to reclassify the neonatal unit from a special care unit to a routine area since it meets the requirements for a special care unit as set forth in 42 C.F.R. § 413.53. Specific requirements met by the neonatal unit includes the following:

- It is physically separate from general routine areas;
- The unit has specific written policies;
- It has registered nursing care available on a continuous 24 hour basis with at least one registered nurse present in the unit at all times; and
- The unit maintains a minimum nurse-patient ratio of one nurse to two patients per patient day.

Regarding the Provider's argument that its neonatal unit must qualify as a Level 3 unit under State classification to be recognized as a special care unit, the Intermediary contends that the Medicare regulations have no such requirement. As to the Provider's argument that its neonatal unit is a "step down unit" or "intermediate care unit," the Intermediary believes this argument is without merit since there are no other neonatal units at the hospital with a higher

level of care. The fact that another hospital used for the transfer of patients has a higher level of care does not transform the Provider's unit into a step-down unit.

The Intermediary rejects the Provider's attempt to compare its neonatal unit with a neonatal unit in another hospital. The applicable regulations require that classification of a unit as a special care unit should include comparisons with other special care units in the same provider. Different providers can set up special care units based on different criteria and staffing decisions. Whereas one provider may decide a one to one nursing staff ratio is necessary in its neonatal unit, another can decide that the nursing ratio should be two to one. Both could be classified as special care units, yet the unit with a one to one ratio might appear to provide more intensive care than the other.

Based on the facts, the Intermediary concludes that the Provider's neonatal unit met the requirements for classification as a special care unit under 42 C.F.R. 41 413.53(d). Further, the Provider had classified the unit as a special care unit historically as well as in the cost reporting period under appeal. It was only when the Provider realized that such classification would have a negative impact on GME reimbursement that a change in the classification of the unit was sought. The Provider should not be allowed to reclassify the unit after the fact for the sole purpose of improving its Medicare program reimbursement.

Issue 3 - Investment Income:

For the fiscal year under appeal, the Provider determined the amount of its net investment income and allocated the income amount proportionately against capital-related interest expense, non-capital-related interest expense and non-allowable interest expense. Upon audit, the Intermediary made a series of adjustments to only allow the investment income to be offset against allowable interest expense.

PROVIDER'S CONTENTIONS:

The Provider contends that the Intermediary's adjustments are incorrect and inconsistent with the regulations at 42 C.F.R. § 413.153 and 42 C.F.R. § 413.130(g)(2) and the manual provision HCFA Pub. 15-1 § 202. Under regulation 42 C.F.R. § 413.153 and HCFA Pub. 15-1 § 202, interest expense is required to be reduced by investment income. However, the Intermediary is not permitted to offset the income only against allowable interest expense. In support of its position, the Provider cites the Board's decision in Florida Medical Center, Inc. v. Blue Cross and Blue Shield Association/Blue Cross and Blue Shield of Florida, PRRB Dec. No. 93-D63, July 28, 1993, Medicare & Medicaid Guide (CCH) ¶ 41,618 ("Florida Medical Center"),[10] wherein the Board found that investment income earned on loans not related to patient care should not be used to reduce a provider's allowable interest expense.

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[10] Provider Exhibit TT.

With respect to the provisions of 42 C.F.R. § 413.130(g)(2), it is the Provider's position that this regulation requires investment income to be prorated or allocated among capital-related interest expense, operating interest expense and non-allowable interest expense. Again the Provider cites the Board's decision in Florida Medical Center where the Board found that 42 C.F.R.
§ 413.130(g)(2) requires that only that portion of investment income that bears the same relationship to total investment income as the portion of capital-related interest bears to total interest expense be offset against capital-related costs.

The Provider believes that the Board's decision in Florida Medical Center correctly interprets the Medicare law and regulations regarding the issue in this case. Accordingly, the Intermediary's adjustments should be reversed, and the unidentified investment income should be offset against the various types of interest expense according to the proportion of that type of interest expense to total interest expense.

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that its computation of the investment income offset is accurate pursuant to the regulatory requirements of 42 C.F.R. § 413.153. In support of its determination, the Intermediary relies on the HCFA Administrator's decision in Florida Medical Center which reversed the Board's findings on this issue.[11] In that case, the Administrator found that 42 C.F.R. § 413.153(b)(2) requires that necessary interest expense must be reduced by investment income. Accordingly, only the Provider's allowable interest expense is to be offset by the Provider's total investment income.

CITATIONS OF LAW, REGULATIONS AND PROGRAM INSTRUCTIONS:

1. Laws - 42 U.S.C.:

§ 1395x(v)(1)(A)	-	Reasonable Cost
§ 1395ww(d)(5)(B)	-	Payment to Hospitals for Inpatient Hospital Services - Indirect Medical Education Costs
§ 1395ww(h)	-	Payment for Direct Graduate Medical Education Costs

[11] Intermediary Exhibit I-5.

2. Regulations - 42 C.F.R.:

§ 412.118	-	Determination of Indirect Medical Education Adjustment
§ 413.118(b)	-	Determination of Number of Beds
§ 413.5	-	Cost Reimbursement: General
§ 413.9	-	Cost Related to Patient Care
§ 413.53(d)	-	Criteria for Identifying Intensive Care Type Units
§ 413.86	-	Direct Graduate Medical Education Payments
§ 413.130(f)(2)	-	Capital Related Cost - Interest Expense/Investment Income Offset
§ 413.153	-	Interest Expense
§ 413.153(a)(1)	-	Interest Expense - Principle
§ 413.153(b)(2)(iii)	-	Investment Income Offset

3. Program Instructions - Provider Reimbursement Manual, Part I (HCFA Pub. 15-1):

§ 202	-	Interest Expense
§ 226	-	Funded Depreciation
§ 2202.7	-	Special Care Units/Intensive Care Type Units
§ 2405.3	-	Adjustment for Indirect Cost of Medical Education
§ 2405.3G	-	Bed Size
§ 2510.5A	-	Bed Size Definition

4. Case Law:

Sioux Valley Hospital v. Blue Cross and Blue Shield Association/Blue Cross and Blue Shield of Iowa, PRRB Dec. No. 92-D53, August 26, 1992, Medicare & Medicaid Guide (CCH) ¶ 40,747, rev'd by HCFA Admin. October 26, 1992, Medicare & Medicaid Guide (CCH) ¶ 41,044, aff'd sub. nom. Sioux Valley Hospital v. Sullivan, Civ. No. 92-4200 (D.S.D. October 23, 1993) (unpublished) aff'd Sioux Valley Hospital v. Shalala, 29 F. 3d 628 (8th Cir. 1994) (unpublished decision table).

Bowen v. Georgetown University Hospital, 488 U.S. 204 (1988).

St. Elizabeth Hospital, Inc. v. Bowen, 797 F. 2d 449 (7th Cir. 1986).

Humana Hospital University v. Blue Cross and Blue Shield Association/Blue Cross and Blue Shield of Kentucky, PRRB Dec. No. 95-D15, January 4, 1995, Medicare & Medicaid Guide (CCH) ¶ 43,021, rev'd by HCFA Admin., February 21, 1995, Medicare & Medicaid Guide (CCH) ¶ 43,140.

Florida Medical Center Inc. v. Blue Cross and Blue Shield Association/Blue Cross and Blue Shield of Florida, PRRB Dec. No. 93-D63, July 28, 1993, Medicare & Medicaid Guide (CCH) ¶ 41,618, mdfy'd by HCFA Admin., September 23, 1993, Medicare & Medicaid Guide (CCH) ¶ 41,790, aff'd Florida Medical Center, Inc. v. Shalala, No. 94-7026-CIV-KLR, (DC SD Fla. Feb. 27, 1996).

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board after considering the facts of the case, parties' contentions and evidence submitted, finds and concludes as follows:

Issue 1 - Necessary Borrowing:

Based on the "Stipulation and Statement of Uncontested Facts" submitted by the parties, it is undisputed that the Provider expended $3,029,012 from its operating funds during the period of September, 1985 through September, 1988 for the linear accelerator project, which was capitalized by the Provider in October, 1988. Subsequent to the completion of the project, the Provider and IHFA signed a loan agreement on December 8, 1988, in the amount of $3,029,023.[12] In describing the application of the loan proceeds, Article II, Section 2.01 (i) of the loan agreement states the following:

> (2) $3,029,023.00 will be applied to reimburse Borrower for all or portion of the cost, heretofore paid by Borrower, of the items described in Division II of

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[12] Exhibit 5 - Stipulation and Statement of Uncontested Facts.

> Exhibit A hereto. All of said items were acquired, constructed and/or installed by Borrower subsequent to June 1, 1985, and capitalized as fixed assets from construction in progress as of October 31, 1988.

The parties further stipulated that the loan proceeds of $3,029,023 were received by the Provider and deposited into its funded depreciation account. On May 31, 1989, $3,100,000 in funds were transferred from the funded depreciation account to an operations fund account because the funds for the linear accelerator project had been expended from operating funds. The funds were later used for a cogenerator project which totalled $3,200,000.

Given the above undisputed facts, the Board finds that the Provider has not established a financial need for this capital-related borrowing during the fiscal year ended June 30, 1989, as required under the controlling regulatory provisions of 42 C.F.R. § 413.153 and manual instructions set forth in HCFA Pub. 15-1 § 202.2. Moreover, the record demonstrates that the Provider had sufficient operating funds during the three-year construction period to fully finance the ongoing expenditures incurred for the project. Since operating funds are available for patient care purposes, capital or non-capital expenditures, the Provider had accessible funds which it chose to use for the linear accelerator project.

While the Provider argues that it functioned as its own general contractor and was required to use its own funds as interim financing, the Board finds that this argument does not address the necessary borrowing question that is at issue in this case. First, if the Provider is suggesting that a provider can borrow operating funds from itself on an interim basis as justification for a future borrowing, the Board finds such an argument to be self defeating. If sufficient existing funds are available to satisfy a financial need, the Medicare program expects these unrestricted funds to be used in order to avoid interest expense attributable to unnecessary borrowings. With respect to the permanent financing obtained from IHFA, the Provider must justify a need for this borrowing when the loan was actually incurred. The replenishment of previously utilized operating funds does not satisfy this requirement. The Board is cognizant of the necessity of long-range planning and the need to commit funds when major capital improvements and acquisitions are contemplated. However, a financial need for the incurrence of debt must be demonstrated at the time of the capital indebtedness in order to be considered a necessary borrowing under the Medicare program. The Provider has not met its burden of proof for the IHFA loan at issue in this case for the fiscal year ended June 30, 1989.

Issue 2 - Neonatal Unit:

The majority of the Board finds that the Provider's neonatal unit is not an intensive care unit and, thus, should be treated as a newborn nursery with the associated beds and days excluded from the IME and GME calculations, respectively. The majority believes that its position is fully supported by the 7th Circuit's decision in St. Elizabeth, wherein the Court found that a provider's special care unit must provide the same comparable level of care as an intensive care unit ("ICU"). If the care provided falls below that mark, then it is by definition routine

care. The facts in this case support the St. Elizabeth Court's premise in that the average charges and costs per patient day and nursing hours per day for the neonatal unit were in-between the Provider's other ICU units and the nursery.[13] The nursing hours per day in the ICUs ranged from 16.0 to 16.3 based on the type of nursing services included in the calculation. By contrast, the neonatal unit only had 14.2 of nursing hours per patient day for the fiscal year ended June 30, 1989. Since the units have dissimilar levels of nursing hours per patient day, the units are not comparable, and the neonatal beds and days should not be included in the IME and GME payment formulas.

The Board majority further finds that the Provider's exclusion of the neonatal beds was also in agreement with the regulatory provisions of 42 C.F.R. § 412.118 (formerly 42 C.F.R. § 405.477(d)(2)). The recodified regulation at 42 C.F.R. § 412.118 revised the prior regulation to clarify the policy for determining the number of beds used in the IME calculation. Whereas the prior regulation at 42 C.F.R. § 405.477(d)(2) was silent as to the inclusion or exclusion of specific types of hospital beds in the IME calculation, paragraph, (b) of 42 C.F.R. § 412.118, as amended and recodified September 3, 1985, provides the following specific instructions for determining the number of beds:

> [f]or purposes of this section, the number of beds in a hospital is determined by counting the number of available bed days during the cost reporting period, not including beds assigned to newborns, custodial care, and excluded distinct part hospital units, . . .

42 C.F.R. § 412.118(b) emphasis added).

The majority of the Board finds no ambiguity in this regulation change. The revised regulatory instructions clearly exclude all beds assigned to newborns, and contain specific instructions which relate directly to the computation of the IME cost adjustment factor. The Intermediary's determination ignores this governing regulatory rule. The Board majority also notes that another change to HCFA's instructions was necessary in August of 1988 with the revision of HCFA Pub. 15-1 § 2405.3G. While this policy change only excludes beds assigned to newborns which are not in intensive care areas, the Board majority finds that this instruction cannot be applied retroactively. Since the manual revision (Transmittal No. 345) has an effective date of August 25, 1988, which is after the beginning of the fiscal year in controversy for this case (FYE June 30, 1989), it is the Board majority's judgment that this manual provision cannot be applied to the Provider's situation.

The majority of the Board is aware of the decision rendered by the United State Court of Appeals for the 8th Circuit in Sioux Valley. Based on its review of that decision, the majority does not give great weight to the court's findings as they apply to this case and respectfully disagrees with its interpretation and application of the existing rules and instructions. While

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[13] Provider Exhibit U.

the court found the language of the regulations ambiguous, the Board majority finds the language of the regulations clear in their instruction and application.

The majority of the Board further notes that the court agreed in part with the Board's decision in Sioux Valley in that the retroactive application of HCFA Pub. 15-1 § 2405.3G would be an improper and arbitrary act under the circumstances. Accordingly, the court stated that it did not rely upon this ground for including intensive care beds for newborns in the IME formula. Also noteworthy is the court's response to the Secretary's argument that the inclusion of intensive care beds in the available bed count was a longstanding requirement under the Medicare program. While the court acknowledged that this may be a correct assertion of a consistent and concurrent policy followed by the Secretary, the record before it did not support such a contention. Therefore, the court did not base its decision upon this rationale either. As in the instant case, the Board majority is not persuaded that the court's decision in Sioux Valley correctly applies existing policy to the cost reporting period in contention.

As a final point, the Board majority notes that the regulation at 42 C.F.R. § 412.105(b), formerly § 412.118(b), was modified again in 1995 to further clarify the bed counting rules for IME purposes. In this latest policy modification, the regulatory language specifically excludes from the IME calculation beds or bassinets in the healthy newborn nursery, custodial care beds, or beds in excluded distinct part hospital units. The Board majority views this latest correction as a substantive change in the regulations which finally establishes a prospective regulatory rule which can be implemented by providers in a consistent and straightforward manner.

Issue 3 - Investment Income:

The Board finds that the unidentified investment income earned by the Provider should be offset against the various types of interest expense incurred by the Provider (i.e., capital-related interest, non-capital-related interest and non-allowable interest) based on the ratio each interest category bears to the total interest expense.

The regulation at 42 C.F.R. § 413.153 establishes the basic principles for the reimbursement of interest expense under the Medicare program and states the following:

> [n]ecessary and proper interest on both current and capital indebtedness is an allowable cost.

42 C.F.R. § 413.153(a)(1).

In defining the term "necessary", the regulation at 42 C.F.R. § 413.153(b)(2)(iii) requires that the interest be "reduced by investment income . . ." The regulation at 42 C.F.R. § 413.130(f)(2) addresses the offset of investment income in relation to capital-related costs as follows:

> [i]f investment income offset is required under § 413.153(b)(2)(iii), only that portion of investment income that bears the same relationship to total investment income, as the portion of capital-related interest expense bears to total interest expense, is offset against capital-related costs.

42 C.F.R. § 413.130(f)(2).

The Board believes that the correct determination of the investment income offset requires a prorata distribution to each interest expense classification. This calculation affects both the amount of interest expense allowed as required by 42 C.F.R. § 413.153, and the amount of income offset as required by 42 C.F.R. § 413.130(f)(2).

DECISION AND ORDER:

Issue 1 - Necessary Borrowing:

The Intermediary's necessity of borrowing determination with regard to the Provider's Illinois Health Facility Authority ("IHFA") loan was proper and is affirmed.

Issue 2 - Neonatal Unit:

The Intermediary improperly included the Provider's neonatal unit beds and days in the indirect medical education ("IME") calculation and graduate medical education ("GME") patient load calculation for the fiscal year ended June 30, 1989. The Intermediary's adjustments are reversed.

Issue 3 - Investment Income:

The Intermediary did not properly allocate the Provider's investment income consistent with the allocation of interest expense. The Intermediary's determination is reversed.

Board Members Participating:

Irvin W. Kues
James G. Sleep
Teresa B. Devine
Henry C. Wessman, Esquire (Dissenting Opinion - Issue 2)

FOR THE BOARD:

Irvin W. Kues
Chairman

Dissenting Opinion of Henry C. Wessman (Issue 2)

I concur with my learned colleagues on Issues 1 and 3; I chose to dissent on Issue 2.

I take judicial notice of the Administrator's October 26, 1992 reversal of the Board's decision in PRRB Dec. No. 92-D53, dated August 26, 1992, as affirmed by the district court in South Dakota and upheld by the 8th Circuit (Sioux Valley Hospital v. Blue Cross and Blue Shield Association/Blue Cross and Blue Shield of Iowa, PRRB Dec. No. 92-D53, August 26, 1992, Medicare & Medicaid Guide (CCH) ¶ 40,747, rev'd by HCFA Admin., October 26, 1992, Medicare & Medicaid Guide (CCH) ¶ 41,044, aff'd sub. nom. Sioux Valley Hospital v. Sullivan, Civ. No. 92-4200 (D.S.D. October 23, 1993) (unpublished), aff'd Sioux Valley Hospital v. Shalala, 29 F.3d 628 (8th Cir. 1994) (unpublished decision table). I am persuaded by the weight of stare decisis, and the logic that the amendment to PRM Section 2405.3G, effective August 25, 1988, was intended to clarify existing policy with interpretive rather than substantive changes. The manual change issued by HCFA, effective August 25, 1988, sent a clear signal as to the IME calculation. The timing of the effective date (August 25, 1988) was such that the Provider in this case knew, or should have known, the formula to be used for the cost reporting period in question. That formula clearly identified that beds in "special care units" were to be counted for purposes of the IME cost adjustment calculation.

Further, I take note of the fact that the Provider has historically classified the unit in question as a "special care unit" under 42 C.F.R. § 413.153(d).

For the above reasons, the Intermediary's adjustments should be upheld.

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Henry C. Wessman, Esquire
Board Member