PROVIDER REIMBURSEMENT REVIEW BOARD
HEARING DECISION

98-D29

PROVIDER -The Parkway Hospital, Inc.
Forest Hills, New York

Provider No. 33-0041

vs.

INTERMEDIARY -
Empire Blue Cross and Blue Shield

DATE OF HEARING-
September 23, 1997

Cost Reporting Period Ended -
December 31, 1986 and 1987

CASE NO. 89-1782

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ISSUE:

Were the Intermediary's adjustments reclassifying the lease rental costs reported as capital costs proper?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

The Parkway Hospital, Inc. ("Provider") is a 227 bed proprietary facility located in Forest Hills, New York.[1] As an acute care hospital located in New York, the Provider became subject to the Medicare prospective payment system ("PPS") on January 1, 1986.[2] The Provider's Medicare cost reporting periods ended December 31, 1986 and 1987, which are at issue in this appeal, were PPS transition periods. This means that part of the Provider's reimbursement for inpatient hospital services was based upon a hospital-specific rate ("HSR") per discharge derived from the Provider's 1982 base period, while certain other costs, such as capital-related costs, were classified as "pass-through" items which continued to be reimbursed on the basis of reasonable cost.

Empire Blue Cross and Blue Shield ("Intermediary") audited the Provider's cost reports for the subject reporting periods and found that the Provider had claimed capital pass-through reimbursement for certain equipment lease payments pursuant to 42 C.F.R. § 412.71(b)(2). The Intermediary determined, however, that these costs were classified as operating costs during the Provider's base period and were included in the Provider's HSR. Therefore, to avoid paying for the same costs twice, once through the HSR and again as capital pass-through costs, the Intermediary reclassified the lease payments back to their respective cost centers as operating expenses.[3]

On November 28, 1988, the Intermediary issued a Notice of Program Reimbursement ("NPR") reflecting the reclassifications for the Provider's 1986 cost reporting period, and on March 24, 1989, the Intermediary issued an NPR reflecting the reclassifications for the Provider's 1987 cost reporting period. On May 8, 1989, the Provider appealed each of the Intermediary's determinations to the Provider Reimbursement Review Board ("Board") pursuant to 42 C.F.R.
§§ 405.1835-.1841, and met the jurisdictional requirements of those regulations. The amount

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1 Intermediary's Position Paper at 1.

2 Most hospitals located outside of New York became subject to PPS with cost reporting periods beginning on or after October 1, 1983. New York hospitals were exempt from PPS until December 31, 1985 pursuant to 42 U.S.C. § 1395b-1. Provider's Post-Hearing Brief at 3.

3 Provider's Post-Hearing Brief at 3-4. Intermediary's Position Paper at 2.

of Medicare reimbursement in controversy is approximately $168,000 for the 1986 cost reporting period, and $222,000 for 1987.

The Provider was represented by Roy W. Breitenbach, Esquire, of Garfunkel, Wild & Travis, P.C. The Intermediary was represented by Michael F. Berkey, Esquire, of the Blue Cross and Blue Shield Association.

PROVIDER'S CONTENTIONS:

The Provider contends that the Intermediary improperly reclassified rental payments made on various equipment leases from capital-related expenses to operating expenses for its 1986 and 1987 cost years. The reclassifications denied the Provider capital pass-through treatment for the subject rental payments thereby reducing the Provider's overall Medicare reimbursement.[4]

The Provider asserts that two requirements must be met in order for items of expense to be reimbursed as capital pass-through costs during PPS transition years.[5] First, the costs must meet the Health Care Financing Administration's ("HCFA") definition of a capital-related cost. 42 C.F.R. § 413.130, Provider Reimbursement Manual, Part I ("HCFA Pub. 15-1") § 2806. This requirement is not relevant to the instant case since the Intermediary has not contested that the rental payments at issue meet the pertinent definition.[6]

Secondly, however, the provider must demonstrate that the subject costs were also treated as capital-related costs during its PPS base year, which is commonly referred to as "the consistency rule".[7] Manual instructions at HCFA Pub. 15-1 § 2802(B)(1) state:

> [d]uring this [the PPS transition] period, classification of an item as either a capital-related expense or a current operating expense must not be changed in subsequent fiscal years from its classification status in the base period cost report. Further, hospitals will not be permitted to change their policies during the transition period from those used in the base period regarding capitalizing or expensing the items. Intermediaries will assure that any cross-over of items from operating expense categories to capital-related categories will not be allowed in reimbursing hospitals during the transition period.

HCFA Pub. 15-1 § 2802(B)(1).

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4 Provider's Post-Hearing Brief at 23.

5 Id.

6 Provider's Post-Hearing Brief at 25.

7 Provider's Post-Hearing Brief at 26.

With respect to this requirement, the Provider contends that the Intermediary denied capital pass-through treatment for the subject lease payments because the Provider could not demonstrate that these costs had also been treated as capital-related costs during its base year.[8] The Provider argues, however, that the Intermediary's position is flawed because all of the costs at issue pertain to equipment that was acquired after the 1982 base year. The Provider asserts that the costs at issue relate to new equipment which it did not possess during the PPS base year, nor was acquired to replace equipment that was available in the PPS base year.

The Provider cites Kaiser Foundation Hospitals Group -- Pass Through Costs v. Ætna Life Insurance Company, PRRB Dec. No. 92-D10, February 12, 1992, Medicare & Medicaid Guide (CCH) ¶ 40,016 ("Kaiser"). In that case, the Board held that HCFA's consistency rule is satisfied where a provider can show that the equipment was acquired after the PPS base year and, therefore, constituted "new, non-replacement equipment".[9]

The Provider adds that all the appellants in Kaiser had a 1982 PPS base year, and leased or purchased various assets during their 1984, 1985, and 1986 cost years. Then, these providers claimed the rental payments and purchase prices of the assets as capital-related costs. After auditing the cost reports, the intermediary reclassified these capital-related costs as operating expenses, thereby denying capital pass-through treatment for the costs associated with the newly acquired equipment. The intermediary based its decision on HCFA's consistency rule. The
Board, however, rejected the intermediary's position, stating:

> [t]he Board finds the Intermediary's argument that it must consistently apply the base-year treatment to assets purchased after 1983 incorrect. The law and regulations must be applied each year to a provider's incurred costs. In 1984, 1985, and 1986, the Providers incurred costs for newly leased and purchased assets. Reimbursement for these costs is dictated by whatever regulations apply at that time. The Board believes that this treatment of post-1983 purchases and leases of assets also meets the intent of HCFA Pub. 15-1 §2802.B.1. That section limits consistent treatment of base-year period operating or capital-related costs to assets purchased or leased in the base period. It does not "lock in" the treatment of assets purchased after the base year. Thus, the Board concludes that this section is in accord with the Medicare law and regulations. The Intermediary has improperly applied the consistency standard.

Kaiser, Medicare & Medicaid Guide (CCH) ¶ 40,016 at 29,587.

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[8] Provider's Post-Hearing Brief at 27.

[9] Id.

In accordance with the Board's decision in Kaiser, the Provider asserts that it is also entitled to capital pass-through reimbursement for the subject rental payments because it can demonstrate that the equipment was acquired after its 1982 base year, and that the equipment was "new, non-replacement equipment."[10]

The Provider contends that the fact the subject equipment was acquired after its PPS base period is evidenced by testimony rendered by its witness. Before the Board, the witness testified that a 1983 Chevrolet Van was leased in June 1983,[11] and that a 1986 Chevrolet Van was leased in August 1986.[12] Similarly, the witness testified that EKG monitoring equipment was acquired in 1983,[13] mammography equipment was acquired in 1986,[14] and angiography equipment was acquired in 1984.[15] Additionally, a coulter counter was acquired in 1984,[16] enhanced operating room lights and tables in 1985,[17] and C-arm x-ray equipment in 1984.[18] Finally, the witness testified that the Provider acquired a computerized registration system, enhanced patient beds, and a CT scanner in late 1986.[19]

The Provider contends that the fact the subject equipment was not acquired to replace equipment it had possessed during the 1982 base year is also evidenced by testimony. In this regard, the Provider's witness testified that the Provider never had, or needed, a van to transport records and other materials from its off-site storage facility before June 1983.[20] Likewise, the Provider never had mammography equipment before 1986,[21] or angiography

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10 Provider's Post-Hearing Brief at 29.

11 Transcript ("Tr.") at 39.

12 Tr. at 44.

13 Tr. at 45.

14 Tr. at 50.

15 Tr. at 60.

16 Tr. at 57.

17 Tr. at 53 and 55, respectively.

18 Tr. at 61.

19 Tr. at 63-65.

20 Tr. at 40.

21 Tr. at 50.

equipment before 1984.[22] Also, the coulter counter acquired in 1984 was the first coulter counter possessed by the Provider.[23] The C-arm x-ray equipment acquired in 1984 was the first C-arm x-ray equipment the Provider had ever possessed [24] and, finally, the Provider never had a computerized registration system,[25] or a CT scanner on its premises before 1986.[26]

With respect to the remaining equipment at issue in this appeal, the EKG monitoring equipment, the operating room tables and lights, and patient beds, the Provider asserts that it had possessed similar equipment during its PPS base year. However, the equipment at issue was especially enhanced and could perform so many more features than the equipment available in 1982, that it should not be considered replacement equipment, but rather, entirely new equipment of a different category.[27]

For example, the Provider asserts that while it had several freestanding analog EKG monitors in use during 1982, the EKG monitors acquired in 1983 were computerized, connected to a central station network, and provided physicians with simultaneous interpretation of the results. These are all features that the 1982 EKG monitors lacked.[28] The new EKG monitors also gave physicians on the Provider's medical staff who did not specialize in cardiology the ability to read and interpret the EKG results without having to await the arrival of cardiologists, which is an essential function that the earlier EKG monitors did not provide.[29]

Similarly, the Provider possessed operating room tables, operating room lights, and patient beds during its 1982 base year. However, the operating room tables, operating room lights, and patient beds acquired after 1982 all had enhanced capabilities and many more features than the equipment previously possessed. The operating room tables available in 1982 were the original tables installed by the Provider when the hospital was built in 1963. These tables did not enable surgeons to place patients in different positions during an operation or for the

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22 Tr. at 60.

23 Tr. at 57.

24 Tr. at 61.

25 Tr. at 64.

26 Tr. at 65.

27 Provider’s Post-Hearing Brief at 30.

28 Tr. at 46-47.

29 Id.

postoperation recovery period. The tables acquired by the Provider in 1985 were mechanical, thereby allowing patients to be placed in different positions.[30]

Likewise, the lights acquired by the Provider in 1985 replaced lights that had been in the Provider's operating room since 1963, and were unsatisfactory because they cast large shadows on the operating field. The new lights had enhanced technology which enabled surgeons to view more of the operating field.[31]

The Provider disagrees with the Intermediary's suggestion that the operating room lights, operating room tables, and patient beds that were acquired after 1982 were actually replacement equipment pursuant to the Board's decision in Kaiser.[32] The Provider asserts that in Kaiser the Board defined replacement equipment in terms of the potential for duplicate reimbursement, as follows:

> [t]he Board does recognize that a potential for duplicate reimbursement may exist for leases or assets that replace existing leases or assets. Without proper accountability of these capital-related costs, duplication will result. Treating a capital-related cost as an operating expense in the base year and continuing to reimburse the Providers on this basis during the PPS transition period, while treating replacement assets and leases subsequent to 1983 on a capital-related cost reimbursement basis, can result in duplicate reimbursement . . . . The costs of those replacements should not be treated as capital-related costs, since the costs of the original assets are included in the hospital-specific portion of the Providers' PPS rates.

Kaiser, Medicare & Medicaid Guide (CCH) ¶ 40,016 at 29,587.

With respect to the instant case, the Provider argues that there is no risk for double reimbursement. The operating room tables, operating room lights, and patient beds had been in the Provider's possession since the hospital was built in 1963. Therefore, this equipment was fully depreciated before the 1982 base year and, accordingly, no costs associated with this equipment were included in the Provider's hospital specific rate.[33]

The Provider also disagrees with the Intermediary's suggestion that it did not establish the subject equipment to be new, non-replacement equipment, because it relied solely upon the

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30 Tr. at 54.

31 Tr. at 55-56.

32 Provider's Post-Hearing Brief at 32.

33 Provider's Post-Hearing Brief at 33.

testimony of a witness who did not become affiliated with the Provider until 1987.[34] The Provider asserts this argument is misplaced because the witness' testimony was based not only on his personal knowledge, but on his extensive review of the Provider's records and the available lease documents. In addition, as the witness explained, he obtained additional information from members of the Provider's medical staff, technical staff, and administration who were present and working for the Provider during the periods of the equipment acquisitions.

The Provider asserts that the Intermediary's criticism of its witness' testimony as unreliable "hearsay" is also misplaced.[35] Both the Board and the Administrative Procedure Act give the Board the right to accept hearsay and other testimony that would be inadmissible under the Federal Rules of Evidence or traditional court procedures. See HCFA Pub. 15-1 § 2925.2, (Board not bound by traditional evidentiary rules); Mercy Hospital v. Blue Cross and Blue Shield Association, PRRB Dec. No. 91-D66, Aug. 23, 1991, (accepting hearsay evidence introduced at hearing); See also 5 U.S.C. § 556(d), (all oral or written evidence admissible in federal administrative hearings except evidence that is irrelevant, immaterial, or unduly repetitious); Richardson v. Perales, 402 U.S. 389, 402 (1971) ("Richardson") (hearsay evidence properly admitted in federal administrative hearing); Bennett v. National Transportation Safety Board, 66 F.3d 11 30, 1137-38 (10th Cir. 1995) (same); Calhoun v. Bailar, 626 F.2d 145, 148 (9th Cir. 1980) (same) ("Calhoun"). As the Ninth Circuit stated in Calhoun:

> [p]erhaps the classic exception to strict rules of evidence in the administrative context concerns hearsay evidence. Not only is there no administrative rule of automatic exclusion for hearsay evidence, but the only limit to the admissibility of hearsay evidence is that it must bear satisfactory indicia of reliability. We have stated the test of admissibility as requiring that the hearsay be probative and its use fundamentally fair.

Calhoun, 626 F.2d at 148.

The Provider adds that the reason for the relaxed rules of evidence in administrative proceedings was best explained by the Supreme Court when discussing the administrative hearing rules under the Social Security Act.[36] The Court stated:

> [i]t is apparent that (a) the Congress granted the Secretary [of Health and Human Services] the power by regulation to establish hearing procedures; (b)

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34 Id.

35 Id.

36 Provider's Post-Hearing Brief at 34.

> strict rules of evidence, applicable in the courtroom, are not to operate at social security hearings so as to bar the admission of evidence otherwise pertinent; and (c) the conduct of the hearing rests generally in the examiner's discretion. There emerges an emphasis upon the informal rather than the formal. This, we think, is as it should be, for this administrative procedure, and these hearings, should be understandable to the layman claimant, should not necessarily be stiff and comfortable only for the trained attorney, and should be liberal and not strict in tone and operation. This is the obvious intent of Congress so long as the procedures are fundamentally fair.

Richardson, 402 U.S. at 400-01 (Blackmun, J.).

The Provider concludes that its witness' testimony meets the requirements of relevance, materiality, and fundamental fairness.[37] The witness explained in detail what information was based on his personal knowledge, what information was based on his review of pertinent records, and what information was obtained from specified other persons. In total, the witness' testimony was corroborated by the relevant Provider records and lease documents, and the Provider offered to submit corroborative affidavits from the persons with whom the witness spoke.

Finally, the Provider contends that the Intermediary's argument regarding discrepancies in its lease documentation is improper, and that it has met its burden to establish that the rental payments at issue are entitled to capital pass-through treatment.[38] The Provider argues that it claimed capital pass-through reimbursement for the subject costs in each of the pertinent Medicare cost reports. The Intermediary audited these cost reports and raised no questions regarding lease documentation or costs. Furthermore, although the Intermediary had several opportunities to express any concerns it may have had regarding the Provider's documentation, it waited until the day of the hearing, after the Provider's witness had completed his testimony, to raise them. Accordingly, the Provider asserts that the Board should reject these Intermediary arguments as untimely and inappropriate.

The Provider explains that the Intermediary raised only one objection to its claim, and that was the classification of the rental payments as capital-related costs violated the consistency rule. The Intermediary did not raise any audit or verification objections to the rental payments in either its 1986 or 1987 NPRs. Clearly, after audit, the Intermediary accepted the amount of rental payments claimed by the Provider in their entirety, and only reclassified these total amounts from capital-related costs to operating expenses.

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[37] Provider's Post-Hearing Brief at 35.

[38] Provider's Post-Hearing Brief at 36.

In addition, the Intermediary did not include any audit and verification objections in its List of Issues submitted to the Board after the Provider filed its request for a Board hearing. Similarly, the Intermediary did not raise any audit and verification objections in its Position Paper. Also, several months before the hearing, the Provider submitted a letter brief which set forth, in detail, what the Provider's claims would be at the hearing. Accompanying this brief was a complete set of the Provider's exhibits. Even after receiving and reviewing this documentation, the Intermediary still did not inform either the Board or the Provider that it intended to raise any audit and verification objections at the hearing. Clearly, for the Intermediary to raise audit and verification objections with respect to information it had audited more than five years earlier is
unfair.

The Provider adds that it has long been a fundamental principle of administrative law that an agency's decision may be upheld, if at all, solely upon the grounds stated by the agency itself. Burlington Truck Lines, Inc. v. United States, 371 U.S.156,168-69(1962) ("Burlington Truck Lines"); SEC v. Chenery, 332 U.S. 194, 195-97 (1947) ("Chenery II"); SEC v. Chenery, 318 U.S. 80, 93-95 (1943) ("Chenery I"); Phelps Dodge Corp. v. NLRB, 313 U.S. 177, 195-97 (1941). A reviewing body may not rely upon "post-hoc rationalization" regarding legal conclusions in support of agency action but not appearing on the face of the decision. Burlington Truck Lines, 371 U.S. at 168-69; Chenery I, 318 U.S. at 94; Compania De Gas DeNuevo Laredo, S.A. v. FERC, 606 F.2d 1024, 1031 (D.C. Cir. 1979).

Here, however, the Intermediary seeks to do precisely what administrative law forbids, i.e., use a legal argument not appearing on the face of its NPRs to sustain its reclassification of the rental payments after the Provider demonstrated that its stated reason for reclassification was without merit. The Intermediary's actions are particularly egregious given that it waited more than five years after it audited the Provider's cost reports and supporting documentation to raise its audit and verification objections. Had the Intermediary raised its objections at the time it issued the NPRs, the Provider could have addressed them and provided additional documentation. By waiting so long after the NPRs were issued to raise the objections, the Intermediary effectively denied the Provider the ability to respond because neither the Intermediary nor the Provider has records documenting the Intermediary's audit of the necessary information. The Provider explains that it had repeatedly asked the Intermediary for information concerning its 1986 and 1987 lease schedules, but the Intermediary never provided any information supporting or disproving the schedules.[39]

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that its adjustments reclassifying the subject lease rental costs as operating expenses are proper. The Provider treated the costs of equipment leases as operating expenses during its 1982 PPS base period. Accordingly, these costs were included

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[39] Tr. at 163.

in the Provider's HSR, and they must be treated the same way in the subject cost reporting periods to avoid duplicate payments. The Intermediary asserts its adjustments are proper based upon HCFA's rules pertaining to the consistent treatment of capital-related costs found at 42 C.F.R.
§ 412.113(a) and HCFA Pub. 15-1 § 2802.[40]

The Intermediary contends that there are three issues that refute the Provider's claim that the subject costs should be treated as capital pass-through costs. First, there is no proof that the lease costs the Provider wishes to claim as capital pass-through costs were not reimbursed in its HSR.[41] As shown on Exhibit I-H, which is a form showing adjustments to the Provider's 1982 PPS base period cost report, there is a Memorandum Entry indicating that the Provider treated all lease payments as operating expenses. The Memorandum Entry states:

> [i]t should be noted for ceiling computations the Provider has no capitalized lease obligations. The lease rental expense included in the cost centers are for operating leases only.

Adjustments to the Institutional Cost Report for the Year Ended December 31, 1982 at 9.[42]

Accordingly, the Intermediary contends that the Provider claimed no lease expenses as capital-related costs in its PPS base period, and that all lease expenses that were incurred were claimed as operating costs that are reimbursed through the Provider's HSR.[43] The Intermediary asserts that the immediate problem is that no records are available to indicate which equipment lease expenses were actually included in the Provider's HSR. Therefore, there is no way to determine whether or not the lease payments now being claimed by the Provider as capital pass-through costs pertain to the same equipment whose costs are included in the HSR, and whether or not such pass-through treatment will result in duplicate payments. The Intermediary explains that it simply has no records or listing of the leases included in the Provider's HSR, and neither does the Provider.[44]

The Intermediary also asserts that it would be improper to rely upon Provider testimony to determine whether or not certain capital lease expenses were included in the Provider's HSR, and which expenses were not. The Intermediary argues that pursuant to Medicare regulation

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40 Intermediary's Position Paper at 2, 4 and 5.

41 Tr. at 13.

42 Exhibit I-H

43 Tr. at 16.

44 Tr. at 18.

42 C.F.R. §§ 413.20 and 24, adequate cost data must be available to support provider claims.[45] Also, regarding the parties' inability to identify the specific lease costs included in the Provider's HSR, the Intermediary rejects the Provider's reliance on the Board's conclusions in Kaiser to help support its position. The Intermediary argues that a complete reading of the decision reveals that capital pass-through treatment is allowed for capital lease costs incurred after the base period only where the asset acquired was totally "new" to the Provider, as follows:[46]

> . . . capital-related lease and depreciation costs incurred after the PPS base year are allowed pass-through treatment unless the assets replace those which were treated as operating costs in the base year. All hospitals, whether paid under the prospective payment system or excluded, must treat capital-related costs in a manner consistent with the way identical or similar costs were treated in the base year.

Kaiser, Medicare & Medicaid Guide (CCH) ¶ 40,016 at 29,586 (Emphasis added).

Accordingly, the Intermediary asserts that where the Provider incurred lease expenses in the PPS base year for items such as cars and operating tables, as in the instant case, the Medicare program cannot treat expenses for those items as capital pass-through costs in the transition years. The Intermediary argues that it does not have to be the same cars or operating tables, and it does not even have to be identical equipment, only equipment that is similar to that used in the base period. For the purpose of this case, the Intermediary argues that if the lease expenses of an X-ray machine were included in the Provider's HSR, then the costs of a CAT scan leased after the base period should not be allowed capital pass-through treatment because it is a similar piece of equipment.[47]

The Intermediary again refers to the Board's conclusion in Kaiser, which states in part:

> [t]he Board does recognize that a potential for duplicate reimbursement may exist for leases or assets that replace existing leases or assets. Without proper accountability of these capital-related costs, duplication will result. Treating a capital-related cost as an operating expense in the base year and continuing to reimburse the Providers on this basis during the transition period, while treating

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45 Tr. at 19.

46 Tr. at 20.

47 Tr. at 21.

> replacement assets and leases subsequent to 1983 on a capital-related cost reimbursement basis, can result in duplicate reimbursement.

Kaiser, Medicare & Medicaid Guide (CCH) ¶ 40,016 at 29,587.

Next, the Intermediary contends that the Provider's claim for capital pass-through treatment must be denied because there is no evidence that the subject purchases were even made. The Intermediary explains that for all but about $35,000 worth of the lease expenses at issue in this case there are no actual lease documents available to verify the transactions. The Intermediary argues that Exhibits P-10 and P-12 are the only two leases available.[48] However, the Provider is claiming that it entered about 10 leases totaling approximately $125,605 in capital pass-through costs in 1986, and $392,275 in 1987. The Intermediary explains that the actual leases are necessary to determine exactly what the Provider purchased, the terms of the transaction, who has ownership, etc.[49]

Finally, the Intermediary contends that the Provider's claim for capital pass-through treatment must be denied because there are numerous reconciliation problems and inconsistencies in the Provider's records which cannot be audited or verified. For example, the Intermediary asserts that Exhibit I-I shows where certain lease costs are inexplicably claimed in some years but not in others, and where there are significant differences in the amount of certain lease costs claimed from one year to the next.[50] Additionally, the Intermediary refers to its cross-examination of the Provider's witness, Tr. at 66, which discloses numerous differences in lease amounts in various different Provider documents which could not be explained.

In addition, the cross-examination revealed differences in the amount of the Intermediary's adjustments being disputed by the Provider. The pertinent adjustment made by the Intermediary to the Provider's 1986 cost report was the reclassification of $246,297 in lease rental costs. While the Provider originally challenged this entire adjustment, it reduced its challenge to $125,605 just prior to its hearing before the Board.[51] The Provider did not have a reconciliation of these two amounts.[52]

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48 Tr. at 76.

49 Tr. at 13 and 23.

50 Tr. at 169.

51 Tr. at 104-107.

52 Tr. at 134.

Conversely, the Provider increased the amount of the adjustment it disputes for the 1987 cost reporting period from approximately $322,000 in lease rental costs to $392,275. The Intermediary notes that the amount now challenged by the Provider for 1987 is greater than the actual adjustment it made to the Provider's cost report. Moreover, the Provider did not produce a reconciliation of these two amounts, as well.[53]

CITATION OF LAW, REGULATIONS AND PROGRAM INSTRUCTIONS:

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

§ 1395b	-	Option to Individuals to Obtain Other Health Insurance Protection
§ 1395x(v)(1)(A)	-	Reasonable Cost

2. Law - 5 U.S.C.:

§ 556(d)	-	Administrative Procedure Act

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

§ 405.1835-.1841	-	Board Jurisdiction
§ 412.71(b)(2)	-	Determination of Base Year Costs
§ 412.113	-	Payments Determined on a Reasonable Cost Basis.
§ 413.20	-	Financial Data and Reports
§ 413.24	-	Adequate Cost Data and Reports
§ 413.130	-	Capital-Related Costs

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

§ 2802	-	Payment Rates During Transition
§ 2806	-	Capital-Related Costs - General
§ 2925.2	-	Evidence

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[53] Tr. at 104, 105, and 116.

5. Case Law:

Kaiser Foundation Hospitals Group -- Pass Through Costs v. Ætna Life Insurance Company, PRRB Dec. No. 92-D10, February 12, 1992, Medicare & Medicaid Guide (CCH) ¶ 40,016.

Mercy Hospital of Miami v. Blue Cross and Blue Shield Association, PRRB Dec. No. 91-D66, Aug. 23, 1991, Medicare & Medicaid Guide (CCH) ¶ 39,589.

Richardson v. Perales, 402 U.S. 389, 402 (1971).

Bennett v. National Transportation Safety Board, 66 F.3d 1130 (10th Cir. 1995).

Calhoun v. Bailar, 626 F.2d 145, 148 (9th Cir. 1980).

Burlington Truck Lines, Inc. v. United States, 371 U.S. 156 (1962).

SEC v. Chenery, 318 U.S. 80 (1943).

SEC v. Chenery, 332 U.S. 194 (1947).

Phelps Dodge Corp. v. NLRB, 313 U.S. 177 (1941).

Compania De Gas DeNuevo Laredo, S.A. v. FERC, 606 F.2d 1024 (D.C. Cir. 1979).

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board, after consideration of the facts, parties' contentions, and evidence presented, finds and concludes that a portion of the Intermediary's adjustments is improper.

The fundamental issue in this case, whether or not the Intermediary properly reclassified certain lease rental payments from capital costs to operating costs, must be decided on a lease by lease basis considering each individual item involved. This type of analysis is necessary because there are several factors to be considered which may or may not apply in each instance. Initially, it must be determined if a leased item is totally new to the Provider or whether it actually replaced an item that existed in the PPS base period. This review is necessary because there is no record of the lease costs included in the Provider's HSR and, therefore, only costs attributable to "totally new non-replacement" equipment could be treated as capital pass-through costs without jeopardy of paying for the same costs twice, i.e., once through the HSR and again as a pass-through. This review is consistent with the Board's decision in Kaiser.

It must also be determined if there is adequate documentation to support the Provider's claim in each particular instance, and whether or not the Provider's claim is consistent with the financial data placed into evidence. The Board notes that much of its analysis must be based upon Provider testimony since a copy of each applicable lease is not available.

With respect to the individual leases at issue in this case and the specific items of equipment involved, the Board finds as follows:[54]

- 1983 and 1986 Automobiles - The Intermediary's adjustment is proper. The Board is not convinced that the subject vehicles were "totally new"to the Provider's operation. The Provider testified that it owned vehicles during the base period. Therefore, a potential for duplicate payments exists if the 1983 and 1986 automobile lease expenses were allowed capital pass-through treatment, since the costs of the previously owned vehicles may have been included in the HSR. Additionally, the Provider's claim is inconsistent with its financial documentation. Although the term of the 1986 automobile lease extended through July 1989, the Provider did not claim automobile rental expenses in 1987.

- 1983 EKG Equipment- The Intermediary's adjustments are proper. The Board finds that the Provider obtained sophisticated, computerized EKG equipment through the subject lease. However, the Provider possessed EKG equipment in its PPS base period. Although the newer equipment may be far superior to the equipment that was available to the Provider in its PPS base period, it is clearly similar equipment whose costs would create a potential for duplicate payments if they were allowed capital pass-through treatment.

- 1986 Mammography Equipment - The Intermediary's adjustments are improper. The subject mammography equipment was acquired after the Provider's PPS base period, and was not acquired to replace similar equipment. The Board finds that the Provider had no mammography equipment before 1986. Prior to this time, the Provider relied upon a filtered radiography machine to get images of the breast. The Board agrees with the Provider that the filtered radiology process does not produce the same, or even similar results as that obtained from mammography equipment. The Provider's claim is also supported by copies of the applicable leases.

- 1985 Operating Room Tables and Lights - The Intermediary's adjustments are proper. The subject equipment was clearly obtained to replace equipment possessed by the Provider in its PPS base period. Although the subject tables and lights are portrayed to be far superior to the equipment they replaced, they are not so dissimilar as to be considered "new" to the Provider in the context of HCFA's consistency rule.

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[54] See Provider's Post-Hearing Brief at Exhibit 1.

In addition, the Board rejects the Provider's argument that the costs of the subject tables and lights can be afforded capital pass-through treatment because there is no risk of double payment, i.e., because the original tables and lights had been fully depreciated by the time of the PPS base period, and thus none of their costs are included in the HSR. The Board finds this argument inconsistent with a fundamental intent of the HSR, which is to reflect actual base period activity.

- 1984 Coulter Counter - The Intermediary's adjustments are improper. The coulter counter was acquired after the Provider's PPS base period, and was not acquired to replace similar equipment. Prior to obtaining the coulter counter the Provider used a microscope to make random sample analyses of blood counts. A coulter counter is too far advanced from the microscope process to be considered a similar piece of equipment. The Board also notes that evidence of the Provider's costs for the coulter counter are included in its lease schedules.

  The Board emphasizes that the amount of costs improperly reclassified by the Intermediary for the coulter counter are $37,346 for 1986 and $951 for 1987, as shown in Provider's Post-Hearing Brief at Exhibit 1. The Provider explains that the vast difference in these two amounts is attributable to a 1986 refinancing, and that some portion of the 1987 costs for the coulter counter are included in another lease. However, there is no evidence in the record that identifies other costs for the coulter counter and, therefore, the Board restricts its decision to the amounts noted.

- 1984 X-Ray (Angiography) - The Intermediary's adjustment is proper. The subject X-ray appears to have been a "new, non-replacement" piece of equipment considering its unique ability to view the interior structure of a patient's veins and arteries. However, the Board rejects the Provider's claim based upon inconsistencies in the financial evidence presented. Purportedly, the subject lease began in 1984 and ran through 1989. Therefore, the Provider should have incurred costs for this equipment in each of the subject cost reporting periods. However, the Provider is not claiming any costs for the angiography equipment in 1986. In light of this material discrepancy and the lack of any additional substantive documentation such as a copy of the lease, the Board concludes there is insufficient data to support the Provider's claim.

- 1984 Mobile X-Ray - The Intermediary's adjustment is proper. The Board finds that the subject C-arm X-ray is similar to X-ray equipment possessed by the Provider in its PPS base period. Although the C-arm X-ray is portable for ease of operation, it is not so dissimilar in function and purpose from the equipment possessed by the Provider in its base period to be considered "new, non-replacement" equipment. In addition, there are inconsistencies in the financial evidence presented for the C-arm equipment identical to the inconsistencies noted for the angiography equipment, discussed above.

- 1986 Keamed-Hill ROM Lease - The Intermediary's adjustment is proper. Included in this lease are the costs of a CAT scan, a computerized registration system, and patient beds. The Board agrees with the Provider, in that the CAT scan and registration system are "new, non-replacement" items. However, the Board finds that the patient beds are clearly replacement items that may not be allowed capital pass-through treatment due to the risk of duplicate program payments. Since the costs of the items in this lease are commingled, and the costs attributable specifically to the patient beds cannot be isolated, none of the costs associated with this lease may be treated as capital pass-through costs.
- 1987 U.S. West Equipment Leases - The Intermediary's adjustments are proper. The Provider explained that these leases were used to obtain "various pieces" of laboratory equipment. The Provider did not, however, identify the specific items acquired and explain their relationship to laboratory items that it possessed in the PPS base period. Based upon the evidence submitted, the Board is not persuaded that the different pieces of equipment acquired through these leases are, in fact, "new, non-replacement" items.

DECISION AND ORDER:

The costs applicable to the Provider's 1986 Mammography Equipment Lease, amounting to $21,387 in each of the subject cost reporting periods, are capital pass-through costs. The costs applicable to the Provider's 1984 Coulter Counter Lease, which amount to $37,346 in the Provider's 1986 cost reporting period and $951 in the Provider's 1987 cost reporting period, also are capital pass-through costs. All other lease costs were properly reclassified by the Intermediary from capital pass-through costs to operating expenditures. The Intermediary's adjustments are affirmed in part, and reversed in part.

Board Members Participating:

Irvin W. Kues
James G. Sleep
Henry C. Wessman, Esquire

Date of Decision: February 24, 1998

FOR THE BOARD:

Irvin W. Kues
Chairman