# PROVIDER REIMBURSEMENT REVIEW BOARD
# HEARING DECISION

99-D24

**PROVIDER** -Sid Peterson
Memorial Hospital
Kerrville, Texas

**DATE OF HEARING-**
March 26, 1997

Provider No. 45-0007

Cost Reporting Periods Ended -
June 30, 1990, 1991 and 1992

**vs.**

**INTERMEDIARY** -Blue Cross and Blue Shield Association/Blue Cross and Blue Shield of Texas

**CASE NOs.** 93-0688
94-0445
94-2071

**INDEX**

ISSUES:[1]

1. Were the Intermediary's disallowances of interest expense resulting from the sale of the Provider to Sid Peterson Memorial Hospital ("SPMH") proper?

2. Were the Intermediary's adjustments to disallow public relations expense and establish a non-reimbursable cost center for marketing proper?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Sid Peterson Memorial Hospital ("Provider") is a 116-bed, voluntary, nonprofit, general acute care hospital located in Kerrville, Texas. The Provider's facilities were originally constructed in 1949 by the Hal and Charlie Peterson Foundation ("Foundation"), which was organized in 1944 for the purpose of supporting charitable and educational undertakings. The Foundation continued to own and operate the Provider until January 1, 1990, when the assets and operations of the hospital's facilities were transferred to Sid Peterson Memorial Hospital ("SPMH"), a nonprofit Texas Corporation which was formed to own and operate the Provider. For each of the fiscal years under appeal (June 30, 1990, 1991 and 1992), the Provider was owned by SPMH, and claimed costs relating to the issues in dispute on its Medicare cost reports.

Upon completion of its review of the cost reporting years at issue, Blue Cross and Blue Shield Association/ Blue Cross and Blue Shield of Texas ("Intermediary") issued Notices of Program Reimbursement which included adjustments disallowing the disputed costs. The Provider filed timely appeals with the Provider Reimbursement Review Board ("Board") pursuant to 42 C.F.R.
§§ 405.1835 - .1841 and has met the jurisdictional requirements of these regulations.

The Provider was represented by J.D. Epstein, Esquire, of Vinson & Elkins, L.L.P. The Intermediary's representative was Bernard M.Talbert, Esquire, of the Blue Cross and Blue Shield Association.

Issue 1 - Interest Expense:

On December 28, 1989, the Foundation (Seller) and SPMH (Purchaser) entered into an "Agreement and Contract for Sale" which effected the conveyance of all properties (real, personal and mixed, tangible and intangible) that were used in the operation of the Provider's

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[1] Except for the issues stated, all other issues previously appealed by the Provider have been administratively resolved, withdrawn, or consolidated with the remaining issues.

hospital facilities.[2] The Agreement became effective midnight, December 31, 1989, and resulted in no gain or loss on disposition because the sale price was established as the net book value of the assets. SPMH purchased the tangible assets of the hospital for the total price of $17,632,328.84, which was fully financed by the Foundation through the issuance of a promissory note. This promissory note was payable to the Foundation over a 32-year period at an interest rate of 6 percent per annum.[3] In addition, a second promissory note in the amount of $3,117,983.00 was issued for the purchase of various intangible assets and inventories for their net book value at the time of the sale, which was payable one year later at an interest rate of 6 percent per annum.[4]

Based on the testimony of the Provider's witnesses, the sale was prompted by (1) the Foundation's concern over large malpractice awards that could adversely affect the Foundation's other assets; (2) the general desire of the Provider's medical staff to have a greater voice in the daily operations of the Provider; and (3) the recognition that the broader charitable mission of the Foundation and the specific interests of the Provider and its patient care operations did not always coincide.[5] The Foundation made the decision to pursue divestiture of the Provider in October of 1988. However, due to the limitations set forth in the Foundation's charter and by-laws, only charitable, nonprofit organizations would be considered as potential buyers. To ensure that the Provider would continue to serve the community through local control, a separate nonprofit corporation was established for the purpose of acquiring and operating the hospital's facilities.[6]

On February 13, 1989, SPMH was incorporated as a Texas nonprofit corporation for the exclusive purpose of operating a charitable nonprofit hospital in Kerr County, Texas.[7] The three individual incorporators of SPMH were Chas H. Johnston, (Member of the Foundation's Board of Trustees), John M. Mosty (Employee of the Foundation), and Joe Burkett, Jr. (Local Attorney). SPMH was incorporated with a nine-member Board of Directors, of which three directors (Scott F. Stehling, W.C. Mathews, and Judge Julius R. Neunhoffer) were also members of the Foundation's Board of Trustees. The remaining six directors were active and retired physicians and members of the local community.

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[2] Provider Exhibit P-11/Intermediary Exhibit I-2

[3] Provider Exhibit P-12.

[4] Provider Exhibit P-13.

[5] Tr. at 38, 134-135.

[6] Tr. at 69.

[7] Provider Exhibit P-5.

At the first organizational meeting of the SPMH's Board of Directors on March 7, 1989, the directors: (1) elected officers from among themselves; (2) selected a bank; (3) approved the filing for tax-exempt status with the Internal Revenue Services ("IRS"); and (4) appointed advisory directors pursuant to the by-laws of SPMH.[8] SPMH was granted tax-exempt status by the IRS as a Section 501 (c)(3) corporation on June 21, 1989. In anticipation of the proposed sale of the Provider, the Foundation also sought confirmation from IRS that its tax exempt status would not be adversely affected due to the sale of the Provider. In response to the April 3, 1989 request for ruling submitted on behalf of the Foundation by its legal representative, the IRS confirmed in a letter ruling dated December 14, 1989, that the Foundation would continue its tax-exempt status after the sale of the hospital's assets and transfer of the hospital's operations.[9] On December 22, 1989, the Foundation held a special meeting where the Board of Trustees accepted the resignations of Scott F. Stehling, W.C. Mathews, Judge Julius R. Neunhoffer and F.W. Hall, Jr., three of whom were on SPMH's Board of Directors.[10] As of January 1, 1990, the Provider was owned and operated by SPMH, acting through its independent Board of Directors.

In its 1990, 1991 and 1992 cost reports, the Provider claimed interest expense that it paid on the notes to the Foundation for the assets purchased by SPMH. The Intermediary disallowed the interest expense based on its determination that the Foundation had control and or influence over the actions of the Board of Directors of SPMH. Citing the related party principle set forth in § 218 of the Provider Reimbursement Manual (HCFA Pub. 15-1), the Intermediary concluded that the interest claimed on the notes was not reimbursable under the Medicare program. This disallowance of interest expense reduced the amount of Medicare reimbursement by approximately $1,300,000 for the three years in contention.

PROVIDER'S CONTENTIONS:

The Provider contends that the interest expense incurred on SPMH's purchase of the hospital's assets from the Foundation was both necessary and proper as defined in 42 C.F.R. § 413.153(a)(1). The Provider asserts that SPMH and the Foundation are not related parties within the meaning of the regulations at 42 C.F.R. § 413.17. Alternatively, the Provider argues that even if SPMH and the Foundation are related parties, the interest expense should be considered allowable cost because the related party rule does not "per se" require that the interest expense be disallowed. Additionally, both public policy and Medicare program policy favor the sale of a nonprofit, sole community provider to another nonprofit entity that will perpetuate the charitable mission of the Provider.

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[8] Provider Exhibit P-8

[9] Provider Exhibit P-9

[10] Provider Exhibit P-10

Since the Intermediary does not challenge the necessity of the incurred interest expense, the sole question at issue is the propriety of the interest expense under the related party principle. The regulation defines proper interest expense as interest that is:

> (i)... incurred at a rate not in excess of what a prudent borrower would have had to pay in the money market existing at the time the loan was made; and (ii) paid to a lender not related through control or ownership, or personal relationship to the borrowing organization.....

42 C.F.R. § 413.153(b)(3).

The Provider argues that only two questions must be answered to determine whether the interest expense is an allowable cost:

(1) Whether the interest was incurred at a rate not in excess of what a prudent borrower would have had to pay in the money market existing at the time the loan was made; and

(2) Whether the interest was paid to a lender not related through control or ownership, or personal relationship to the borrowing organization.

The Provider contends that the claimed interest expense was proper because it was incurred at a rate not in excess of what a prudent borrower would have paid in the money market existing at the time the loan was made. Based on the testimony of the Provider's Chief Financial Officer, the 6 percent annual rate obtained on the promissory note compares favorably to the average prime rate of 10.5 percent which commercial banks were obtaining for short-term business loans in the later part of 1989.[11] As to the issuance of the tax-exempt bond's, it would have been difficult to obtain such financing under the circumstances of the transaction. This was confirmed by a professional underwriter for one of Texas' largest banks who stated the following in an affidavit on this matter:[12]

> it would have been difficult for SPMH to sell tax-exempt bonds to finance its purchase of the Hospital. Due to the Hospital's small size, its historical dependence upon contributions from the Foundation, its low equity-to-debt ratio, and the Foundation's unwillingness to guarantee the bonds, SPMH was not in a good position to issue bonds. If SPMH could have sold tax-exempt

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[11] Tr. at 100-101.

[12] Provider Exhibit 51

> bonds, such bonds would have been issued without insurance at a rating of "Ba." A rating of "Ba" corresponds to an interest rate range of 8.75% to 9% for long-term bonds (25 years). For short term bonds (10 years), such bonds would carry an interest rate range of 8.2% to 8.4%.

Id.

The Provider believes the clear evidence and uncontroverted testimony shows that, for similar terms for long-term financing, the existing money market only offered more expensive financing alternatives than the promissory note obtained from the Foundation.

As to the second question in determining the propriety of the interest expense, the Provider attests that the interest expense was proper because it was not paid to a related party. The regulations at 42 C.F.R. § 413.17 et seq., provide guidelines for determining related party transactions by defining the terms "common ownership" and "common control." Since both the Foundation and SPMH are nonprofit entities without members or stockholders, or ownership or equity interest in either entity, they cannot be related through common ownership. The Intermediary acknowledges this fact, and instead bases its conclusion that the Provider and the Foundation are related parties due to common control.

Under the regulatory provisions of 42 C.F.R. § 413.17(b)(3), common control exists where an individual or an organization has the power, directly or indirectly, significantly to influence or direct the actions or policies of an organization or institution. The manual provision at HCFA Pub. 15-1 § 1004.3 further states that the term includes any kind of control, whether or not it is legally enforceable and however it is exercisable or exercised. It is the reality of the control which is decisive, not its form or the mode of its exercise. The manual goes on to state that the facts and circumstances in each case must be examined to ascertain whether legal or effective control does, in fact, exist.

The Provider points out that, in order to establish the power to influence or direct another party's actions or policies, there must be tangible factors that exist through which such control could be exercised. In this regard, the case law has typically found such tangible factors to include: (1) authoritative positions held by an individual in both entities; (2) authoritative positions and/or equity interests of a group of individuals or an equity held in both parties; or (3) a contract between two entities that, pursuant to its terms, grants one party significant control over the other party. In addition, the case law has clarified that tangible factors indicative of control must exist at the time of the transaction that produces the issue in question, or the factors must be established through the terms of the contract itself. The Provider emphasizes that prior relationships that included factors indicative of control, however significant, are insufficient to establish relatedness, if at the time of the transaction at issue, such factors are not present or are insignificant.

As an example of individual control, the Provider cites a decision by the Administrator of the Health Care Financing Administration ("HCFA") in Home Health Agency of North Broward, Inc. v. Blue Cross and Blue Shield Association/Blue Cross and Blue Shield of Florida, March 17, 1981, Medicare and Medicaid Guide (CCH) 31,016. In that decision, the Administrator noted the multiple roles played by a single person in both the home health agency provider and its management company, and found the two parties related because the president of the management firm also served as a director and secretary/treasurer of the provider. In addition to other relationship factors, the management firm also made interest-free loans to the provider.

With respect to group control, the Provider cites various Board and court decisions including, Goleta Valley Community Hospital v. Schweiker, 647 F.2d 894 (9th Cir.1980). In that case, the court found relatedness because at the time of the provider's purchase of the facility, the provider's entire board of trustees held a seventy-percent interest in the entity that owned the facility and that entity was a partnership of physicians who owned the facility leased by the provider. Regarding control by contract, the Provider notes that courts and regulatory agencies have also concluded that a provider and supplier may become related parties by virtue of the terms of a management or loan agreement between the parties.

In contrast to the above findings of relatedness through control, the Provider points out that courts and administrative agencies have found that: (1) past relationships do not translate into current relatedness; and (2) ownership of one entity while maintaining a minority seat on the board of directors of another entity at the time the two entities enter into a transaction is insufficient to support a finding of relatedness. Consistent with case law, the Provider insists that the regulatory and manual provisions establish that common control must exist at the time of the transaction. If the transaction is a sale of the provider's assets, and the reimbursement issue concerns depreciation or interest expense relating to the acquired assets, the parties are related only if the factors of control are present at a significant level at the time of the sale. In DCH, Inc. v. Bowen, 1988 WL 235543 (D.Ariz., April 27, 1988), Medicare and Medicaid Guide (CCH) ¶ 37,620, the district court found that a past history of association between the parties could not support relatedness where there was no common control or ownership between the parties at the time of the transaction. The Board similarly ruled in Cole Hospital v. Aetna Life and Casualty Company, PRRB Dec. No. 85-D98, August 28, 1985, Medicare and Medicaid Guide (CCH) ¶ 34,966 ("Cole"), stating that a prior related party relationship is not controlling as to the status of the parties at the time the contract was executed, at which time the parties were held not to be related.

In determining the "time of the transaction," the Provider proposes that the case law has followed a bright-line test rather than nebulous concepts concerning the content of negotiations leading up to a transaction. A bright-line test is preferable to the Intermediary's approach of randomly selecting events occurring prior to a transaction as within a "continuum of events" that should be used to measure relatedness. This subjective test cannot be consistently applied to readily determinable facts, as can the logical bright-line test. The cases

view the time of the transaction at the time a party's board of directors approves the transaction or at the time the transaction is executed. In this case, the SPMH Board of Directors approved the agreement to purchase the hospital's assets on December 22, 1989. The Foundation's Board of Trustees approved the agreement on December 22, 1989. The agreement was executed by the Foundation and SPMH on December 28, 1989. At the time of SPMH's purchase of the Provider from the Foundation, no factors indicative of control were present. There were no overlapping board members, employees, officers or agents, and neither entities had the power to appoint or remove directors to or from the board of the other. The Foundation had no actual ability, inferred ability, or possibility to control SPMH through any person or group, nor the desire or incentive to do so. As to the Intermediary's reliance on the Board's decision in Eastland Memorial Hospital v. Blue Cross and Blue Shield Association/Blue Cross and Blue Shield of Texas, PRRB Dec. No. 96-D37, June 20, 1996, Medicare and Medicaid Guide (CCH) ¶ 44,478 ("Eastland"), the Provider argues that the facts in that case are dissimilar to the present case. In Eastland, the Provider transferred its assets to a newly-created hospital district at a time when four of the provider's seven-member board of directors also sat on the hospital district's nine-member board of directors. Unlike Eastland, this case presents no interlocking directorates at the time of the sale, and common board members never constituted a majority of either the Foundation's or SPMH's boards. According to the case law decided by the Board, the Administrator, and the federal courts, the Provider believes the inquiry of relatedness between SPMH and the Foundation need go no further than the measure of relatedness at the time of the sales transaction. Without such a rule, the related organization principle would be so broad that it would encompass every relationship that ever contained factors of control, even if the parties completely severed the relationship and eliminated all indicia of control at some point prior to the transaction.

The Provider argues that the Intermediary's theory of relatedness does not comply with the regulations and the interpretive case law. The Intermediary takes the position that SPMH and the Foundation are related parties based on the premise that there is no evidence of an arm's length transaction between the parties. The Provider believes the Intermediary uses the terms such as "bona fide", "fair market value," "arm's-length transaction", and "selfish bargaining" as a smokescreen to avoid direct application of the actual regulation and interpretive case law to the facts of this case. The Intermediary theory is fundamentally and legally unsound, and fails to consider the basic principle behind the related party rule (ie. if two parties are related according to the regulations and case law, it is "presumed" that there was no arm's-length transaction.) While an arm's-length transaction will not make the parties unrelated, the lack of an arm's-length transaction does not make two parties related. It is the presence or absence of factors indicative of common control or ownership at the time of the transaction that are the determining elements of relatedness.

Under the Intermediary's theory, SPMH and the Foundation are related parties based on (1) a continuum of events and circumstances prior to the transaction; and (2) a determination that the parties did not negotiate and transact at arm's-length. In response to this theory, the Provider argues that every transaction is preceded by a continuum of events. However, if a

continuum of events were sufficient to establish relatedness without regard to the facts in existence at the time of the transaction at issue, two parties could never become unrelated with respect to any particular transaction. The fact that the Foundation created and incorporated SPMH does not establish that after such creation, the Foundation had the power, directly or indirectly, significantly to influence the actions or policies of SPMH. Given the Foundation's limitations in its charter and by-laws regarding ownership and operation of the Provider, the creation of SPMH was the most logical and practical solution for the sale of the Provider's facilities. However, the incorporators are granted no power to direct, control or influence the business of the corporation. As to the Intermediary's contention that the Foundation and SPMH are related organizations because three of the Foundation's nine trustees were also members of SPMH's nine-member board at the time SMMH was incorporated, the Provider states that this argument fails to meet the requirements of case law that the factors indicative of control must be present at the time of the transaction.

Even if events prior to the transaction are considered in determining relatedness, interlocking directorates do not establish common control in itself. There must be evidence that, through the interlocking directorates, one party has the power to influence the actions or policies of the other. In its decision in Cole, the Board found no relationship at the time of the relevant management contract, even though a principle ownership interest in the supplier and a position on the provider's board of directors was held by the same individual. The Board further noted that no evidence was presented to show that this one board member could influence the actions of the other seven members. As in Cole, the three Foundation trustees who transferred to SPMH's board did so for the continuity in operations and patient care, not as a mechanism through which the Foundation could exert control over SPMH. Once the three overlapping directors joined the SPMH board, they did not participate in any decisions of the Foundation relating to the sale. The Intermediary has offered no evidence that the overlapping directors were the mechanism through which the Foundation had the power significantly to influence the actions or policies of SPMH.

The Provider also rejects the Intermediary's allegation that the Foundation could exert influence over SPMH because of the grants it awarded to SPMH during 1990. Again, this argument ignores the requirements that the Foundation have the power significantly to influence the actions or policies of SPMH, and that this power must exist at the time of the revelant transaction. A significant portion of the Foundation's grants is not equivalent to a significant portion of SPMH's revenue or income such that the Foundation could significantly influence the actions of SPMH. The total sum of the grants awarded constituted only 18.5 percent of SPMH's gross income in 1990. In addition, the Provider points out that the grant's themselves offer no opportunity for the Foundation to exercise control over its recipients and carry no conditions or rules except that the recipient use the grant funds as specified in the grant application. The Intermediary's position also fails to recognize that the determination of control and relatedness must be made at the time of the transaction or as a result of the terms of the transaction or contract. The sales agreement does not provide that the Foundation is obligated to make any grants to SPMH, nor does it obligate SPMH to apply for any grants

from the Foundation. While the Intermediary supports its grant theory by referring to the Foundation's ruling request to IRS,[13] and the March 18, 1988 letter to the Foundation from its attorney,[14] neither of these documents amount to an agreement or commitment by the Foundation to make such a grant. This fact is supported by the final IRS ruling which results in adverse tax consequences to the Foundation, and decreasing grant support given to SPMH by the Foundation in subsequent years.

In support of its theory that the Foundation and SPMH are related parties because they did not negotiate at arm's length, the Intermediary relies on two factors: (1) the financial terms of the transaction allegedly were set in advance of the formation of SPMH; and (2) SPMH and the Foundation did not negotiate from the stance of each looking for the best deal it could for its own selfish interest. In response to these allegations, the Provider submits that the financial terms of the sales transaction were not set by the Foundation, and that some changes to the proposed sales price and interest rate did occur during the transaction process. As examples of the barganinig factor, the Provider points out that : (1) SPMH was able to remove from the sales agreement a provision providing for a penalty if its notes to the Foundation were repaid prior to the due dates; and (2) SPMH was not able to include a provision obligating the Foundation to pay any grants to SPMH. Because the Provider and the Foundation, prior to the incorporation of SPMH, ultimately believed that a sales price of net book value and an interest rate of 6 percent was fair market value and these were acceptable terms to both parties, it does not follow that the terms were set by the Foundation and could not be negotiated by the SPMH board.

As to the Intermediary's concept of "selfish bargaining," the Provider believed this argument is overly simplistic and does not comport with the reality of hospital transactions. This argument only focuses on the sales price aspect of the transaction, and ignores other considerations that affect the price that a party may be willing to accept or pay. Other factors that may be unique to a hospital transaction include the corporate structure of the parties, limitations set forth in the articles of incorporation, Medicare reimbursement and utilization, community needs, taxation and tax-exempt requirements, and management philosophies. Each of these elements influence the terms of the transaction in ways that will not result in each party bargaining for a price that is selfishly best. The Provider contends that the transaction between SPMH and the Foundation was no different from other hospital transactions in that certain elements of the health care environment caused each party to view its position realistically, not in a vacuum of "selfishly best price." The Provider notes that the Board also recognized such other considerations in a hospital sale transaction in its decision for Lac Qui Parle Hospital of Madison Inc. v. Blue Cross and Blue Shield Association/Blue

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[13] Provider Exhibit P-33.

[14] Provider Exhibit P-50.

Cross and Blue Shield of Minnesota, PRRB Dec. No. 95-D37, May 10, 1995, Medicare and Medicaid Guide (CCH) ¶ 43, 269. In that decision, the Board stated:

> While [the buyer's right to receive the Medicare loss] may have impacted on the ultimate sales price, the inclusion of such conditions in the bargaining process and the ultimate sales agreement are not uncommon and would be legitimate considerations in the sale of a hospital facility participating in the Medicare program. Moreover, it would be illogical to presume that the Medicare programs's treatment of the loss on disposal of depreciable assets was not a genuine consideration in determining the sales price of the hospital facility.

Id.

The Provider points out that Medicare reimbursement considerations were also a factor in the instant sales transaction, and that the parties ultimately agreed that the sales price should be net book value with an interest rate of less than 10 percent to avoid Medicare reimbursement issues as a result of the sale. Other factors such as the continued ownership and operation of the hospital as a nonprofit, charitable institution, and the preservation of the Foundation's tax-exempt status were also considerations which entered into the sales price determination.

As an alternative argument, the Provider contends that, even if the Board were to find the Foundation and SPMH are related parties, the Intermediary is not required to automatically disallow the interest expense at issue. The regulation at 42 C.F.R. § 413.153(c)(1) states only that a loan between a related borrower and lender "could affect the "bargaining" process that usually accompanies the making of a loan, and could thus be suggestive of an agreement on higher rates of interest or of unnecessary loans." While the courts generally uphold the Intermediary's disallowance of interest expense between related parties, the courts also recognize that some factual circumstances do not warrant a "per se" disallowance. In the district court decision for South Boston General Hospital v. Blue Cross and Blue Shield of Virginia, 409 F. Supp. 1380 (W.D. Va. 1976) ("South Boston"), the court held that the Secretary's failure to scrutinize loans between related parties for the presence of higher interest rates or an unnecessary loan resulted in an inequitable denial of reimbursement for costs incurred. The court noted that the provider acted in good faith to make the transaction bonafide, and that the entire transaction had been undertaken to benefit the community. Because of the rural nature of the locale, the only persons with the requisite management experience were the former owners who became the trustees of the new provider.

The Provider contends that its case presents similar equitable facts as those in South Boston, but without the relatedness between the parties. The sale of the Provider from the Foundation

to SPMH was for the benefit of the community, such that the community could continue to have a nonprofit, charitable hospital whose management had the single duty to manage and perpetuate the only charitable hospital facility in the surrounding area. The Foundation and SPMH acted in good faith to arrive at a bonafide transaction by engaging counsel to draft the sales agreement and supporting promissory notes; hiring an independent CPA firm to value the Providers assets; and seeking the advice of the Intermediary and the Texas Department of Health to determine the regulatory obligations of each party. Further, both the Foundation and SPMH desired that the Provider operate without substantial disruption from the ownership transition. This was demonstrated by the fact that three members of the Foundation's Board of Trustees transferred to SPMH's Board of Directors at the time of SPMH's incorporation to ensure continuity of experience in the Provider's management. As in South Boston, the hospital is located in a rural area and, thus, few individuals with the requisite management experience were available to become directors of SPMH. However, unlike South Boston, there were no overlapping directors between the Foundation and SPMH at the time of the sale, and less than a majority of the Foundation's trustees held positions on SPMH's board prior to the sale. Given the equitable circumstances surrounding the sales transaction and the absence of facts for a clear related parties determination, the Provider believes the exception to the general rule for the disallowance of interest expense should be applied to this case.

Should the Board find that the provisions of 42 C.F.R. §§ 413.17 and 413.153 on related party transaction do preclude reimbursement of the Provider's interest expense, the Provider as a further alternative argument challenges the validity of those regulatory provisions. In particular, the Provider contends that the "per se" disallowance of its interest expense under the regulations would be arbitrary and capricious. The Provider recognizes that the Board does not have the authority to rule on the validity of the regulations, but it is making this alternative argument to preserve the issue for judicial review.

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that its denial of the interest expense associated with the transfer of the Provider's facility from the Foundation to SPMH was a proper determination because the promissory notes used to finance the transaction were between related parties. Based on its review of the Foundations's activity and the continuum of events which occurred prior to the transaction, it is the Intermediary's position that the Foundation had control and/or influence over the actions of SPMH's Board of Directors. Contrary to the Provider's position, the Intermediary argues that it is not possible to decide the relatedness issue in this case by merely looking at a specific transaction date and the specific documents which effected the transfer. The interest expense issue in this appeal presents a unique problem which does not lend itself to the customary related party cases decided by the Board.[15] The Intermediary emphasizes that the issue before the Board is a Medicare reimbursement dispute which does

[15] Tr. at 28-34, 235-237.

not require an abstract discussion of organizational structures. Prior to January 1, 1990, the Foundation owned the hospital facility, operated it, and employed its administrator and medical staff. This was consistent with the Foundation's charter and by-laws which state that the Foundations's main objective was to "build, equip, finance and operate a modern and medically efficient non-profit hospital in Kerrville, Texas."[16] On January 1, 1990, the owner/operator of the hospital facility became SPMH, another non-profit Texas corporation. As a result of this name change, the Medicare program is being asked to recognize on an annual basis an additional $1,000,000 in interest expense which was not present prior to the transaction. If the change of ownership resulted from a bona fide sales transaction conducted in a market-type environment between unrelated parties, then the Intermediary believes that it would be appropriate for the Medicare program to reimburse its share of the financing costs for such a transaction. However, the Intermediary insists that the transaction in the instant case concerns a restructuring whereby the Foundation made an organizational decision to spin off the ownership and operation of the hospital facility to protect the other assets of the Foundation.

The Intermediary argues that the restructuring of the Foundation first surfaced on paper in March of 1988, as set forth in a letter from the Foundation's attorney addressing the prospective restructuring of the Foundation and the hospital.[17] In response to the Foundation's inquiry, the attorney noted that, while the by-laws of the Foundation did identify the operation of the hospital as its main objective and principle beneficiary of the Foundation's activity, the by-laws did not specifically require that the Foundation own and operate the hospital. Accordingly, the attorney advised that, if the hospital is spun-off, the same obligations must be imposed on the new hospital corporation and that it must specifically assume them. The Intermediary contends that the Foundation's creation of the idea to separate the hospital was the starting point of the transaction, and that the strategy outlined in 1988 by the Foundation was the exact plan that was eventually executed at the end of 1989. When you analyze the continuum of events orchestrated by the Foundation which caused the change in ownership of the hospital's assets, the Intermediary concludes that it is absurd to categorize the transaction as a bona fide business sale between unrelated parties.

The Intermediary contends that a review of the facts and the evidence in this case clearly reveals that there was no discrete and selfish bargaining interest, which is the essence of an arm's-length business transaction. There is no evidence that there was ever meaningful negotiations between distinct identifiable adversarial bargaining units (one being a buyer, the other a seller ), with each seeking to obtain the best deal for its own selfish interest, and each ready and willing to walk away from the deal if the outcome is unsatisfactory to its separate business objectives. The Intermediary finds nothing sinister or wrong about the reorganization or restructuring effected by the Foundation given the financial and charitable

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[16] Intermediary Exhibit I-14.

[17] Id.

concerns raised by the Board of Trustees. However, the Intermediary does not believe that the Medicare program should be required to reimburse a portion of an artificially created cost to satisfy the combined interest of the Foundation and SPMH. The interest expense at issue is not a business financing type of cost which emanated from a bona fide sales transaction between unrelated parties.

The Provider believes that it's only necessary to do a head count of the membership of the Foundation's and SPMH's boards when the contracts were executed in December of 1989 for the purpose of determining relatedness. However, the Intermediary insists that the essential business terms of the transaction were set by the Foundation in 1988, and were merely formalized in December of 1989 when the boards were shuffled, the contracts signed, and the transfer of ownership and operation actually occurred. Rather than a sales transaction between an independent and unrelated buyer and seller, the Intermediary argues that the transaction contrived by the Foundation was specifically structured to reach certain tactical objectives, and that those objectives were formally accomplished with the legal consummation of the planned transaction. The Foundation had a vested interest in the formation of the new corporation, and this was reflected in the make-up of the incorporators of SPMH and the membership of SPMH's Board of Directors. Contrary to the Provider's contentions, there is no evidence of negotiation between the Foundation of SPMH over the sales price and interest rate, or that the Foundation attempted to find other buyers which would have agreed to a fair market sales price. The Intermediary considers the IRS ruling that the Foundation and SPMH were separate, unrelated legal entities to be a moot point in deciding the reimbursement of interest expense under the Medicare program. The Internal Revenue Code does not consider indirect control or influence which are key considerations under Medicare regulations. The Intermediary notes, however, that in its response to the Foundation, IRS acknowledges that the proposed sale of the hospital assets is to a separate corporate entity whose formation was initiated by the Foundation's Board of Trustees.[18]

As to the various case law cited by the Provider, the Intermediary argues that with the exception of the Eastland case, the related party issue addressed in those decisions are not on point with the unique problem presented in this case. In the instant case, you have a seller-created buyer for the hospital's assets which creates a straight-line relationship. The same type of straight-line relationship existed in the Eastland case, which the Board recognized as a restructuring to achieve a legitimate operational result. In ruling for the intermediary, the Board did not find the restructuring to be an arm's-length business transaction which should have a cost impact on Medicare reimbursement. In further support of its position, the Intermediary cites the court decision in Hospital Affiliates International, Inc. v. Schweiker, 543 F. Supp. 1380 (E.D. Tenn, 1982) where the determination of relatedness was significantly influenced because the decision to form another entity originated with the existing entity. The Intermediary notes that several points in that court decision parallel the facts in this case as follows:

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[18] Intermediary Exhibit I-7.

- The idea to form a non-profit corporation to own the hospital originated with the Foundation.

- The Foundation did all the groundwork and then created a buyer.

- A member of the Foundations's Board convened the first Board meeting of the new corporation.

- The Foundation issued grants of $5,000,000 to SPMH for operating capital.

- No other bids for the purchase of the facility were solicited.

In summary, the Intermediary contends it is necessary to look at the entire transaction from beginning to end; the motivational factors involved; the participants who planned and effected the eventual transaction; and what the real benefits were and the recipients thereof. The fact that the deal was contractually formalized on one day and closed three days later ignores two years of history which was the driving force in the reorganization and restructuring of the Foundation's organizational activities. It is necessary to look at the totality of the transaction and not an isolated date when the transaction was completed. Based on the facts and evidence presented, it is the Intermediary's conclusion that its determination is consistent with the Medicare program's related party regulations, and that the transaction between the Foundation and SPMH did not produce allowable interest expense.

Issue 2 - Public Relations Costs:

The Provider claimed certain costs as allowable public relations costs for the cost reporting periods in contention. The specific costs at issue included: (i) printed instruction to patients (Caring Card); (ii) an employee award and recognition program (Caring Crew); and (iii) an education program for expectant mothers (Great Expectations). The Intermediary treated the costs associated with these programs as unallowable marketing expense, and reclassified the costs to a nonreimbursable cost center. The Intermediary's adjustments reduced Medicare reimbursement by approximately $35,000 for the three fiscal years in dispute.

PROVIDER'S CONTENTIONS:

The Provider contends that the statutory provisions of 42 U.S.C. § 1395x(v)(1)(A) establish the principle that the reasonable cost of any service shall be the cost actually incurred in the official delivery of health care services determined in accordance with regulations that establish the methodology to be used. The regulation at 42 C.F.R. § 413.9 further describes reasonable cost as necessary and proper costs incurred in the furnishing of services. Such costs are those that are appropriate and helpful in developing and maintaining the operation of patient care facilities and activities, and are common and accepted occurrences in the field of the provider's activities. The Provider asserts that public relations activities at issue are

necessary and proper costs that are helpful in developing and maintaining the operation of patient care facilities and activities and, thus, should be considered reasonable costs.

While the manual provision at HCFA Pub. 15-1 § 2136.2 excludes the reimbursement of advertising costs that are merely intended to increase patient utilization, the provisions of HCFA Pub. 15-1 § 2136.1 allow the cost of public relations activities if the advertising is primarily concerned with the presentation of a good public image and is directly or indirectly related to patient care. The Provider argues that its Caring Card, Caring Crew, and Great Expectations programs relate to items or activities that are primarily intended to maintain or promote a good public image, provide informative material to patients, and are directly or indirectly related to patient care.

The Provider points out that its facility has been designated a sole community hospital under the Medicare program pursuant to 42 C.F.R. § 412.92 et seq. The Provider qualifies for this designation because it is located between 25 and 35 miles from other like hospitals, and at least 75 percent of residents admitted to the Provider are not admitted to other like hospitals within a radius of 35 miles from the Provider. While the Intermediary suggests that local residents have the option of traveling 65 miles to San Antonio to receive medical care, this insinuation ignores Medicare's sole community hospital designation which implicitly recognizes that it is unreasonable to expect patients to travel distances greater than 25 miles to receive general, acute care hospital services. Accordingly, if at least 75 percent of the Provider's patients do not become patients at a hospital within 35 miles of the Provider, advertising would not serve to increase patient utilization.

Under the Provider's Caring Card program, patients are issued identification cards containing various patient information. The Provider argues that the sole function of the Caring Card was to improve the process of admitting and discharging patients by accelerating the process for previously admitted patients. Accordingly, the Caring Card is used for admitting and discharging patients and, thus, is a function directly related to patient care. As to the Caring Crew program, the Provider contends that the program was established to publicly recognize and honor its employees who have shown exceptional caring, concern, and courtesy towards others. All departments and their patients participated in the program, and nominated various employees who showed an extraordinary degree of caring in the performance of their duties. Winners were selected each month and received such amenities as special parking places, free dinners, free portraits, and media recognition. Since winners received media recognition, the Intermediary claims that the Provider was actually advertising to increase patient utilization by including the slogan "Caring Makes the Difference." The Provider argues that the Intermediary's creative interpretation ignores the obvious purpose of the program, which is to improve patient care, employee relations, and the Provider's overall public image.

With respect to the Great Expectations Programs, the Provider contends that this program is designed to educate and encourage expectant parents and families to lead healthier, happier lives, and to promote friendship and support among expectant women. Expectant parents

who participate in the program are entitled to receive; (i) educational booklets containing prenatal and postnatal information; (ii) monthly newsletters on baby care and educational events; (iii) childbirth preparation classes; (iv) monthly coffee breaks for expectant mothers and coupons for guest meals; (v) exercise classes; and (vi) consultation on lactation and breast feeding. While the Intermediary deems this program to be community education for the general public that is not patient care related, it does concede that the program is not designed to increase patient care. However, the Intermediary could not identify any authority for its belief that expectant mothers who pre-register for delivery at the Provider are not patients until they are actually admitted. Contrary to the Intermediary's supposition, the Medicare program does not subscribe to this theory. Under 42 C.F.R. § 412.2 (c)(5), services relating to the patient's future admission rendered within three days prior to such admission are part of the prospective payment for the admission. Accordingly, the Intermediary's reasoning is contrary to common sense, the general practice of medicine, and the Medicare regulations.

The Provider alternatively argues that the Intermediary improperly established a nonreimbursable cost center for the public relations expenses. It is the Provider's position that such expenses should be removed from the cost report through a Worksheet A-8 adjustment, especially with respect to amounts paid to outside vendors. The creation of a nonallowable cost area is governed by HCFA Pub. 15-1 § 2328 which includes the following:

> Nonallowable cost centers to which general service costs apply should be entered on the cost allocation worksheets after all General Service Cost Centers. General service costs would then be distributed to the nonallowable cost centers in the routine "step-down" process....
>
> The Adjustments to Expenses worksheet (e.g., Worksheet A-8 for hospitals) will continue to be used for expense recoveries (rebates, refunds, etc.); adjustments based on the income received; nonallowable costs to which general service costs are not applicable, except that for patient telephones on Adjustments to Expenses worksheet adjustment only on the basis of cost (not revenue received) can be used even though general service costs are applicable; and the amount applicable to Part B for hospital-based physicians (unless the contract includes a proportionate share of general service costs). These items will still be carried forward to the trial balance of expenses worksheet....

HCFA Pub. 15-1 § 2328 (emphasis added).

At the hearing, the Provider's witness testified that 100 percent of the costs deemed nonallowable by the Intermediary were paid to outside vendors. Because payments made to outside vendors do not incur general service costs, the Provider contends that the specific

provisions of HCFA Pub. 15-1 § 2328 requires that Worksheet A-8 be used rather than the creation of a nonreimbursable cost center. Contrary to the Intermediary's belief, general service costs should not be applied to amounts paid to outside vendors regardless of the materiality of the amount included within the department. The Intermediary's allocation of other overhead costs via step-down to a nonallowable cost center related to the Provider's public relations activities is arbitrary and improper. The Provider concludes that any amount deemed nonallowable by the Intermediary should have been offset via a Worksheet A-8 adjustment.

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that its adjustments to the Provider's community relations account were made to properly reclassify the nonallowable marketing expense portion to a nonreimbursable cost center. It is the Intermediary's position that the underlying objective of the disallowed public relations costs was to obtain a marketing edge on other potential sources of care for residents of the Kerrville community. Even though the Provider is a sole community hospital, their patients do have other available choices for obtaining medical care. Contrary to the Provider's position, the Intermediary believes that the Provider is in competition with every medical facility located in San Antonio, Texas, which is approximately 65 miles from the Provider's facility. Accordingly, it is unreasonable for the Provider to state that it did not need to advertise to keep local patients from going to San Antonio to obtain extensive medical services.

Responding to the three specific advertising campaigns addressed by the Provider, the Intermediary contends that the purchased advertising/marketing services costs incurred for the Caring Card, Caring Crew and Great Expectations programs are actually advertising or community education expenses which are nonallowable costs under HCFA Pub. 15-1 § 2136.2. With respect to the Caring Card program, the Intermediary points out that the costs associated with the patient information file/sheet, and the associated brochures for patient information were not included in the calculation of the unallowable advertising/marketing costs. As to the Caring Crew program, the Intermediary realizes that the purpose of this program was to recognize exceptionally caring employees. However, the promotion of the Caring Card and Caring Crew programs through the local newspaper and radio stations were designed to keep the Provider's name in the public mind, and to create the impression that the Provider cares more about its patients than other hospital facilities. Additionally, the Intermediary notes that the advertisements for the Caring Crew and Great Expectations programs were combined on the invoices and, thus, the documentation does not identify costs for a particular campaign.

Regarding the Great Expectations program, the brochures and advertisement for this program show that it was educationally oriented, and encouraged expectant parents and their families to lead healthier and happier lives. Given the purpose of the program, the Intermediary contends that this is obviously community education for the general public, and is not related

to patient care because it is directed to potential patients, and not actual patients, of the Provider's facility. An expectant mother is not a patient of the Provider until she is admitted for delivery. Until that time, the Great Expectations program is merely a community education program that is a nonallowable cost.

The Intermediary further believes that it properly established a nonreimbursable cost center for the disallowed advertising/marketing costs to which general service costs must be applied. The Intermediary determined that the Provider incurred salaries and occupied space related to the advertising/marketing activities. Upon determining the amount of purchased advertising/marketing services that was not allowable, the Intermediary used a ratio of the unallowable amount to determine the portion of other costs in the department that were unallowable. The Intermediary then made a reclassification adjustment to transfer the unallowed portion to a nonreimbursable cost center. The Intermediary argues that if the nonallowable costs represent a significant portion of a particular activity, then general services costs must be allocated to that activity. The Intermediary believes that it met the criteria for establishing a cost center to accumulate the costs of these nonallowable activities, and that its adjustments results in the proper determination of reasonable costs under the Medicare program.

CITATION OF LAW, REGULATIONS AND PROGRAM INSTRUCTIONS:

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

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|---|---|
| § 1395x(v)(I)(A) | - Reasonable Costs |

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

| | |
|---|---|
| § 405.1835 - .1841 | - Board Jurisdiction |
| § 412.2(c)(5) | - Basis of Payment- Inpatient Operating Costs |
| § 412.92 et seq. | - Special Treatment: Sole Community Hospitals |
| § 413.9 | - Cost Related to Patient Care |
| § 413.17 et seq. | - Cost to Related Organizations |
| § 413.153 et seq. | - Interest Expense |

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

| | |
|---|---|
| § 218 | - Interest on Loans from Lenders Related to the Provider |
| § 1004.3 | - Control Rule |
| § 2136.1 | - Allowable Advertising Costs |
| § 2136.2 | - Unallowable Advertising Costs |
| § 2328 | - Distribution of General Service Costs to Nonallowable Cost Areas |

4. Cases:

DCH, Inc. v. Bowen, 1988 WL 235543 (D. Ariz., April 27, 1988), Medicare and Medicaid Guide (CCH) ¶ 37,620.

Goleta Valley Community Hospital v. Schweiker, 647 F. 2d 894 (9th Cir. 1980).

Hospital Affiliates International, Inc. v. Schweiker, 543 F. Supp. 1380 (E.D. Tenn. 1982).

South Boston General Hospital v. Blue Cross and Blue Shield of Virginia, 409 F. Supp. 1380 (W.D. Va. 1976).

Cole Hospital v. Aetna Life and Casualty Company, PRRB Dec. No. 85-D98, August 28, 1985, Medicare and Medicaid Guide (CCH) ¶ 34,966.

Eastland Memorial Hospital v. Blue Cross and Blue Shield Association/ Blue Cross and Blue Shield of Texas, PRRB Dec. No. 96-D37, June 20 1996, Medicare and Medicaid Guide (CCH) ¶ 44,478.

Home Health Agency of North Broward, Inc. v. Blue Cross and Blue Shield Association/ Blue Cross and Blue Shield of Florida, PRRB Dec. No. 81-D7, January 19,1981, Medicare and Medicaid Guide (CCH) ¶ 30, 888, aff'd. HCFA Administrator, March 17, 1981, Medicare and Medicaid Guide (CCH) ¶ 31,016.

Lac Qui Parle Hospital of Madison, Inc. v. Blue Cross and Blue Shield Association/Blue Cross and Blue Shield of Minnesota, PRRB Dec. No. 95-D37, May 10, 1995, Medicare and Medicaid Guide (CCH) ¶ 43,269.

FINDINGS OF FACT, CONCLUSION OF LAWS AND DISCUSSION:

The Board, after consideration of the facts, parties' contentions, evidence presented, testimony elicited at the hearing, and Provider's post-hearing brief, finds and concludes as follows:

Issue 1 - Interest Expense:

The Board finds that there is substantial evidence in the record to demonstrate that the sales transaction executed between the Foundation and SPMH was not a bona fide, arm's-length transaction between unrelated parties pursuant to the related organizations principles set forth in 42 C.F.R. § 413.17. Accordingly, the interest expense incurred on the promissory note issued to finance the transaction is not an allowable Medicare reimbursable cost under the regulatory provisions of 42 C.F. R. § 413.153.

The related organizations regulation at 42 C.F.R. § 413.17 provides for the determination of relationship through either common ownership or common control. In defining common control, the regulation states that "control exists if an individual or an organization has the power, directly or indirectly, significantly to influence or direct the actions or policies of an organization or institution." In the instant case, the Board finds that the Foundation had common control over the actions of SPMH, and that it exercised this power to significantly influence the actions of SPMH in consummating the transfer of the hospital's assets through a contractual sales agreement. The evidence demonstrates that the transaction was based on a preconceived plan that was initiated by the Foundation's Board of Trustees nearly two years prior to the December 28, 1989 transaction date. For example, in response to the Foundation's inquiry concerning the prospective restructuring of the Foundation and the hospital, the Foundation's attorney recommended in his March 18, 1988 letter that the Foundation divest itself of the ownership and operation of the hospital by chartering and organizing a new Texas nonprofit corporation which would assume the same objectives and obligations set forth in the by-laws of the Foundation.[19] In addition, the attorney recommended that both the Foundation and the new hospital corporation obtain appropriate rulings on tax exemption before the "spin-off" is effected, and that the real estate conveyance be based on the current appraised value of transferred assets. This transfer would involve the execution and delivery of appropriate deeds, promissory notes, and the attendant security instruments.

In accordance with the propose restructuring plan, SPMH was incorporated on February 13, 1989 with a nine-member Board of Directors, of which three directors were also members of

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[19] Provider Exhibit P-50.

the Foundation's Board of Trustees.[20] On June 21, 1989, SPMH was granted tax-exempt status by the IRS, and on December 14, 1989, IRS issued a letter ruling which confirmed the Foundation's continued tax-exempt status after the transfer of the hospital's assets and operations.[21] On December 22, 1989, the Foundation's Board of Trustees accepted the resignations of four trustees, three of whom were on SPMH's Board of Directors.[22] On that same date, December 22, 1989, the "Agreement and Contract for Sale" was approved by the respective boards of the Foundation and SPMH.[23]

The Board finds that the evidence clearly shows that the transfer of the hospital's assets and operations was fully controlled by the Foundation as part of an overall strategy to restructure its organization to enhance its financial and charitable mission and desired goals. The notion to legally separate the hospital from the Foundation's corporate structure originated with the governing body of the Foundation, and the planned manner of achieving this objective was developed, orchestrated, and implemented by the Foundation in every respect (Seller-Created Buyer). Under the common control principle set forth in 42 C.F. R. § 413.17, the Board finds that there is no question from the record that the Foundation and SPMH were related parties when the entire transaction was specifically planned. The reality that the transaction was executed almost precisely as planned demonstrates the continuation of substantial control in fact.

While the Provider asks the Board to look only at the events at the time of the transaction and subsequent to the actual transfer, the Board believes that this approach ignores the substantial evidence and continuum of events which demonstrates the Foundation's power to influence the final outcome of the transaction. The record shows that the Foundation was the driving component for the restructuring of its organization, and that the final outcome of its structured reorganization had to be in agreement with the primary purpose of the Foundation. The minutes of a board meeting held by the Foundation on June 7, 1947 stated the following:[24]

> "After much discussion and general exchange of views and taking into consideration the future course of the Foundation, the following facts were established:

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[20] Provider Exhibits P-5 and P-8.

[21] Provider Exhibits P-5 and P-9.

[22] Provider Exhibit P-10.

[23] Provider Exhibits P-40 and P-53.

[24] Provider Exhibit P-4.

> FIRST, the main objective of this Foundation is to establish a non-profit hospital in the city of Kerrville for the benefit of the people of the Hill Country in general.
>
> Second, the aim of this Foundation is to perpetuate this hospital in the years to come by providing some sort of continuous and lasting revenue."

Id.

The Board believes that, given the main objective of the Foundation, it was essential that the Foundation's Board of Trustees retain full control over the "spin off" of the hospital facility in order to assure compliance with its charter and by-laws.

It is the Board's conclusion that there is substantial evidence in the record to establish that the Foundation had direct power to significantly influence the actions of SPMH and, thus, was able to fashion and control the sales transaction consistent with the objectives of the Foundation. While the substantial evidence is sufficient to demonstrate direct power to control, it is without question that the Foundation at least had the indirect power significantly to influence or direct the actions of SPMH at the time of the transaction as delineated in the related organizations regulation at 42 C.F.R. § 413.17. The Board further notes that, absent the limited testimony of the Provider's witnesses, the record is void of any evidence that the sales transfer was a bona fide, arm's-length transaction which emanated from meaningful negotiations between unrelated parties. The interest expense regulations at 42 C.F.R. § 413.153 require that interest be necessary and proper to be allowable under the Medicare program. One of the elements required for interest to be proper is that the interest must be paid to a lender not related to the provider through common ownership or control. The interest expense claimed by the Provider on the promissory note payable to the Foundation was incurred on a loan between related parties and, thus, is not allowable under the Medicare program. Since the Board is bound by the explicit provisions of 42 C.F.R. §§ 413.17 and 413.153, it does not have the authority to grant an exception to the Medicare rule which requires the disallowance of interest expense in this case.

Issue 2 - Public Relations Costs:

The Board finds that the Provider's public relations expenses for its Caring Card, Caring Crew and Great Expectations programs are allowable expenses in accordance with 42 C.F.R. § 413.9 and HCFA Pub 15-1 § 2136.1. With respect to the Caring Card and Caring Crew programs, it is the Board's conclusion that these programs are directly related to patient care and the enhancement of the Provider's public image. As a sole community hospital, the Board does not believe that the Provider needed to advertise to increase patient utilization.

The Board finds that the Intermediary has failed to present sufficient evidence which would clearly distinguish that the costs incurred were advertising costs rather than public relations expenses.

With respect to the Great Expectations program, the Board finds that the Intermediary's adjustments do not identify the portion of its disallowances that relates to outside vendor payments for public relations expenses versus education costs relating to expectant mothers. Since the Board cannot discern the type of costs at issue and considers the amount in question to be de minimis, the costs reported and claimed by the Provider should be reinstated.

DECISION AND ORDER

Issue 1 - Interest Expense:

The Intermediary's disallowance of interest expense resulting from the sale of the Provider to SPMS was proper. The Intermediary's determination is affirmed.

Issue 2 - Public Relations Costs:

The Intermediary improperly disallowed public relations expenses and established a non-reimbursable cost center for marketing. The Intermediary's adjustments are reversed.

Board Members Participating:

Irvin W. Kues
James G. Sleep
Henry C. Wessman, Esq.
Martin W. Hoover, Jr., Esq.
Charles R. Barker

**Date of Decision**: February 23, 1999

For The Board:

Irvin W. Kues
Chairman