# PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2024-D25

**PROVIDER –**
Lindsborg Community Hospital

**PROVIDER NO**. –
17-1358

**vs.**

**MEDICARE CONTRACTOR –**
WPS Government Health Administrators

**HEARING HELD –**
January 24-25, 2023

**FISCAL YEAR END**– 09/30/2015

**CASE NO. –** 17-1027

**INDEX**

## ISSUE STATEMENT:

Whether the Medicare Contractor properly disallowed the allocated related party costs claimed by Lindsborg Community Hospital ("Provider" or "Lindsborg") for fiscal year ("FY") 2015.[1]

## DECISION:

After considering Medicare law and regulations, the arguments presented, and evidence admitted, the Provider Reimbursement Review Board ("PRRB" or "Board") finds that the Medicare Contractor's disallowance of the allocated related party costs claimed by Lindsborg for FY 2015 was proper.

## INTRODUCTION:

Lindsborg is located in Lindsborg, Kansas and, during FY 2015, it was classified as a critical access hospital ("CAH").[2] The Medicare contractor[3] assigned to Lindsborg is WPS Government Health Administrators ("Medicare Contractor").[4]

During FY 2015, Lindsborg was a controlled entity of Salina Regional Health Center ("Salina Regional").[5] On its FY 2015 as-filed cost report, Lindsborg claimed, as allowable related-party costs on Worksheet A-8-1, certain costs of Salina Regional *allegedly* related to managing and operating Lindsborg, "including Lindsborg's share of the cost of services that were provided by Salina Regional to both Lindsborg and to itself."[6] The Medicare Contractor disallowed the related-party costs claimed by Lindsborg, on the basis that they were not "actually incurred," or at the very least were not substantiated as "reasonable and necessary for delivery of patient care."[7] The Medicare Contractor's adjustments resulted in $1,383,886 of related-party costs being disallowed for FY 2015, "reducing Medicare reimbursement by $826,739."[8] Lindsborg timely appealed the Medicare Contractor's final decision for FY 2015 and met all jurisdictional requirements for a hearing before the Board.

The Board held a live hearing by video conferencing on January 24 and 25, 2023. Lindsborg was represented Robert E. Mazer, Esq. of Baker, Donelson, Bearman, Caldwell & Berkowitz, P.C. The Medicare Contractor was represented by Edward Lau, Esq. of Federal Specialized Services.

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[1] The parties were unable to agree on an issue statement. Day 1 Transcript (hereinafter, "Tr.") at 6-7. The Provider's issue statement was as originally framed as "whether the Medicare Contractor improperly disallowed certain related-party costs claimed by Lindsborg on the grounds that Lindsborg had not incurred the cost." *Id*. at 6. The Medicare Contractor's issue statement was originally framed as "[w]hether the Provider is entitled to reimbursement for costs which were allocated to them from another entity but were never substantiated by the Provider." *Id.* at 6-7.

[2] Provider's Final Position Paper (hereinafter, "Provider's FPP") at 1.

[3] CMS' payment and audit functions under the Medicare program were historically contracted to organizations known as fiscal intermediaries ("FIs") and these functions are now contracted with organizations known as Medicare administrative contractors ("MACs"). The term "Medicare contractor" refers to both FIs and MACs as appropriate and relevant.

[4] Medicare Contractor's Final Position Paper (hereinafter, "Medicare Contractor's FPP") at 1.

[5] Provider's FPP at 1.

[6] *Id.* at 8.

[7] *See* Medicare Contractor's FPP at 24.

[8] Provider's FPP at 11.

**STATEMENT OF FACTS:**

***A. CAHs Paid on Reasonable Cost Basis; Defining Reasonable Costs***

Since October 1, 1983, the Medicare Program has paid most hospitals for the operating costs of inpatient hospital services under the inpatient prospective payment system ("IPPS").[9] Under IPPS, the Medicare Program pays predetermined, standardized amounts per discharge, subject to certain payment adjustments.[10] However, CAHs (*i.e.*, critical access hospitals) are *not* paid under the IPPS, but rather are paid on a reasonable cost basis.

The predecessor to a CAH was the rural primary care hospital ("RPCH"), which was established as a demonstration program on June 25, 1993, after Congress created two new designations for hospitals and facilities, one of which was the RCPH.[11] The initial RPCH demonstration program was limited to seven states; however, in 1997, Congress replaced it with a new, nationwide program which allowed states to designate rural facilities as CAHs if they met certain criteria.[12] Existing RPCHs were automatically deemed as CAHs, and it was at this time that CAHs began to be paid on a reasonable cost basis outside of the IPPS.[13] Rather than being paid a set amount per discharge, CAHs are currently paid 101 percent of their reasonable costs of providing inpatient hospital services.[14]

42 U.S.C. § 1395x(v)(1)(A) defines reasonable costs as follows:

> The reasonable cost of any services shall be the cost actually incurred, excluding therefrom any part of incurred cost found to be unnecessary in the efficient delivery of needed health services, and shall be determined in accordance with regulations . . . .

42 C.F.R. § 413.9 dictates that payments to providers for patient care must be reasonable, which includes necessary and proper costs. The same regulation also defines reasonable cost:

> (a) *Principle.* All payments to providers of services must be based on the reasonable cost of services covered under Medicare and related to the care of beneficiaries. **Reasonable cost includes all necessary and proper costs incurred in furnishing the services**, subject to principles relating to specific items of revenue and cost. . . .
>
> (b) *Definitions*—(1) *Reasonable cost.* Reasonable cost of any services must be determined in accordance with regulations establishing the method or methods to be used, and the items to be included. The regulations in this part take into account **both direct and**

[9] *See* 42 U.S.C. § 1395ww(d)(l)-(5); 42 C.F.R. Part 412.
[10] *See* 42 U.S.C. § 1395ww(d)(l)-(5); 42 C.F.R. Part 412.
[11] Omnibus Budget Reconciliation Act of 1989, Pub. L. 101-239, §§ 6003(g), 6116, 103 Stat. 2106, 2145, 2219 (1989); 58 Fed. Reg. 30630, 30630 (May 26, 1993).
[12] *See* Balanced Budget Act of 1997, Pub. L. 105-33, § 4201, 111 Stat. 251, 369 (1997).
[13] 62 Fed. Reg. 45966, 45970, 46008 (Aug. 29, 1997).
[14] 42 U.S.C. § 1395f(l)(i).

> **indirect costs** of providers of services. The objective is that under the methods of determining costs, the costs with respect to individuals covered by the program will not be borne by individuals not so covered, and the costs with respect to individuals not so covered will not be borne by the program. . . .
>
> (2) *Necessary and proper costs.* Necessary and proper costs are costs that are appropriate and helpful in developing and maintaining the operation of patient care facilities and activities. They are usually costs that are common and accepted occurrences in the field of the provider's activity.
>
> (c) *Application.* (1) It is the intent of Medicare that payments to providers of services should be fair to the providers, to the contributors to the Medicare trust funds, and to other patients.
>
> (2) The costs of providers' services vary from one provider to another . . . . [reimbursement based on reasonable cost] is intended to meet the actual costs, however widely they may vary from one institution to another. This is subject to a limitation if a particular institution's costs are found to be substantially out of line with other institutions in the same area that are similar in size, scope of services, utilization, and other relevant factors.
>
> (3) . . . Reasonable cost includes all necessary and proper expenses incurred in furnishing services, **such as <u>administrative costs</u>**, maintenance costs, and premium payments for employee health and pension plans. **It <u>includes</u>** both **direct <u>and</u> indirect costs** and normal standby costs. . . .[15]

Thus, under the IPPS, a provider's specific cost for providing services, including any associated indirect or administrative and general ("A&G") costs, does not determine the amount of payment for those services; but rather, payment is made based upon a predetermined, standardized amount per discharge.[16] However, CAHs are paid on a reasonable cost basis and reimbursed at 101 percent of the Medicare share of such costs *actually incurred*, including A&G costs, but only *so long as* they are "necessary and proper" and are not "substantially out of line" with similarly situated institutions.

In line with the definitions above, the Provider Reimbursement Manual, CMS Pub 15-1 ("PRM 15-1"),[17] § 2102.1 gives the following definition of "reasonable costs":

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[15] (Bold and underline emphasis added.)
[16] *See supra* note 10 and accompanying text.
[17] *Available at* https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals-Items/CMS021929 (last visited May 20, 2024).

> Reasonable Costs.--Reasonable costs of any services are determined in accordance with regulations establishing the method or methods to be used, and the items to be included. Reasonable cost takes into account both direct and indirect costs of providers of services, including normal standby costs. *The objective is that **under the methods of determining costs**, the costs for individuals covered by the program are not borne by others not so covered and the costs for individuals not so covered are not borne by the program*.
>
> Costs may vary from one institution to another because of scope of services, level of care, geographical location, and utilization. *It is the intent of the program that providers are reimbursed the **actual costs** of providing high quality care*, regardless of how widely they may vary from provider to provider, except where a particular institution's costs are found to be substantially out of line with other institutions in the same area which are similar in size, scope of services, utilization, and other relevant factors. Utilization, for this purpose, refers not to the provider's occupancy rate but rather to the manner in which the institution is used as determined by the characteristics of the patients treated (i.e., its patient mix - age of patients, type of illness, etc.).
>
> *Implicit in the intention that actual costs be paid to the extent they are reasonable is the expectation that the provider seeks to minimize its costs and that **its actual costs do not exceed what a prudent and cost-conscious buyer pays for a given item or service***. (See §2103.) If costs are determined to exceed the level that such buyers incur, in the absence of clear evidence that the higher costs were unavoidable, the excess costs are not reimbursable under the program.
>
> In the event that a provider undergoes bankruptcy proceedings, the program makes payment to the provider based on the reasonable or actual cost of services rendered to Medicare beneficiaries and not on the basis of costs adjusted by bankruptcy arrangements.[18]

Further, PRM 15-1 § 2103 describes the Prudent Buyer concept as referenced above in the definition of "reasonable costs":

> 2103. PRUDENT BUYER
>
> A. General.--The prudent and cost-conscious buyer not only refuses to pay more than the going price for an item or service, he/she also seeks to economize by minimizing cost. This is especially so when the buyer is an institution or organization which makes bulk purchases and can, therefore, often gain discounts because of the size of its purchases. In addition, bulk purchase of items or services often gives the buyer leverage in bargaining with suppliers for other items or services.

[18] (Bold and italics emphasis added) (last modified Sept. 2012, PRM 15-1 Rev. 454).

> Another way to minimize cost is to obtain free replacements or reduced charges under warranties for medical devices. Any alert and cost-conscious buyer seeks such advantages, and it is expected that Medicare providers of services will also seek them.
>
> B. Application of Prudent Buyer Principle.--Intermediaries may employ various means for detecting and investigating situations in which costs seem excessive. Included may be such techniques as comparing the prices paid by providers to the prices paid for similar items or services by comparable purchasers, spot-checking, and querying providers about indirect, as well as direct, discounts. . . . *Also,* ***when most of the costs of a service are reimbursed by Medicare*** (for example, for a home health agency which treats only Medicare beneficiaries), *examine the costs with particular care*. In those cases where an intermediary notes that a provider pays more than the going price for a supply or service or does not try to realize savings available under warranties for medical devices or other items, in the absence of clear justification for the premium, the intermediary excludes excess costs in determining allowable costs under Medicare.[19]

### *B. Allowability of Related Party Costs*

Cost to related organizations is governed by 42 C.F.R. § 413.17. Subsection (a) of that regulation states:

> (a) *Principle.* Except as provided in paragraph (d) of this section, **costs applicable to services, facilities, and supplies furnished to the provider** by organizations related to the provider by common ownership or control **are includable** in the allowable cost of the provider at the cost to the related organization. However, such cost must not exceed the price of comparable services, facilities, or supplies that could be purchased elsewhere.[20]

The regulation also defines what it means to be "related to the provider,"[21] though the Medicare Contractor has conceded in this case that Lindsborg and Salina Regional are related parties.[22] In describing how to apply the related party cost policy, the regulation explains, in pertinent part:

> (c) *Application*.
>
> ****
>
> (2) If the provider obtains items of services, facilities, or supplies from an organization, even though it is a separate legal entity, and the organization is owned or controlled by the owner(s) of the provider, in effect the items are obtained from itself. . . . Therefore,

[19] (Emphasis added.)
[20] (Bold and underline emphasis added.)
[21] 42 C.F.R. § 413.17(b).
[22] Medicare Contractor's FPP at 24.

> **reimbursable cost should include the costs for these items <u>at the cost</u> to the supplying organization**. However, if the price in the open market for comparable services, facilities, or supplies is lower than the cost to the supplier, the allowable cost to the provider may not exceed the market price.[23]

Chapter 10 of PRM 15-1 echoes the substance of the related party cost regulation. In particular, PRM 15-1 § 1000 repeats the general principle of the allowability of related party costs:

> 1000. PRINCIPLE
>
> Costs applicable to services, facilities, and supplies furnished to the provider *by organizations related to the provider* by common ownership or control are includable in the allowable cost of the provider at the cost to the related organization. However, such cost must not exceed the price of comparable services, facilities, or supplies that could be purchased elsewhere. *The **purpose** of this principle* is two-fold: (1) *to avoid the payment of a **profit factor*** to the provider through the related organization (whether related by common ownership or control), and (2) to *avoid payment of **artificially inflated** costs* which may be generated from less than arm's-length bargaining. (Cross-refer to section 2150ff [entitled "HOME OFFICE COSTS--CHAIN OPERATIONS"].)[24]

Also relevant is the following passage from PRM 15-1 § 1005 as it addresses the determination of related organization costs, stating in pertinent part:

> 1005. DETERMINATION OF A RELATED ORGANIZATION'S COSTS
>
> The related organization's costs include all reasonable costs, direct and indirect, ***incurred*** *in the furnishing of services, facilities, and supplies* ***<u>to the provider</u>***. The intent is to treat the costs incurred by the supplier as if they were incurred by the provider itself. . . .
>
> The provider must make available to the intermediary when requested adequate documentation to support the costs incurred by the related organization, including, when required, access to the related organization's books and records, attributable to supplies and services furnished to the provider. Such documentation must include an identification of the organization's total costs, the basis of allocation of direct and indirect costs to the provider, and other entities served.[25]

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[23] (Bold and underline emphasis added.)
[24] (Bold and italics emphasis added) (last modified Dec. 1982, PRM 15-1 Rev. 272).
[25] (Emphasis added.)

In this case, Lindsborg can claim on its FY 2015 cost report those costs that its related party, Salina Regional, incurred on its behalf during FY 2015. Since Lindsborg is paid on a reasonable cost basis, it is paid for its reasonable A&G costs, including those incurred by Salina Regional on behalf of Lindsborg. The dispute in this case centers on what amount of Salina Regional's A&G and other shared costs for FY 2015, if any, can be properly allocated to Lindsborg.[26] In particular, it raises questions of: (1) how much A&G and other shared costs were "actually incurred" by Salina Regional *on behalf of Lindsborg* versus incurred on its own for its own needs or for *other* entities owned or controlled by Salina Regional;[27] and (2) whether the alleged shared costs at issue are consistent with the prudent buyer concept in PRM 15-1 § 2103 and the principles governing related party costs in PRM 15-1 § 1000.

### *C. Accounting Requirements*

Underlying any claim for Medicare reimbursement based on reasonable cost is the requirement to keep appropriate accounting records and reports. 42 C.F.R. § 413.20 requires:

> (a) *General.* The principles of cost reimbursement require that providers maintain sufficient financial records and statistical data for proper determination of costs payable under the program. Standardized definitions, accounting, statistics, and reporting practices that are widely accepted in the hospital and related fields are followed. . . . Essentially the methods of determining costs payable under Medicare involve making use of data available from the institution's basis accounts, as usually maintained, to arrive at equitable and proper payment for services to beneficiaries.
>
> * * * *
>
> (d) *Continuing provider recordkeeping requirements*. (1) The provider must furnish such information to the contractor as may be necessary to –
>
> (i) Assure proper payment by the program, including the extent to which there is any common ownership or control (as described in § 413.17(b)(2) and (3)) between providers or other organizations, and as may be needed to identify the parties responsible for submitting program cost reports;
>
> (ii) Receive program payments; and
>
> (iii) Satisfy program overpayment determinations.
>
> (2) The provider must permit the contractor to examine such records and documents as are necessary to ascertain information pertinent to the determination of the proper amount of

[26] *See* Day 1 Tr. at 12 (Provider's Representative noting that direct costs were claimed on the cost report, recognized by the Medicare Contractor, and not at issue in this appeal). *See also* Day 2 Tr. at 139.

[27] For example, Salina Regional "was also the sole owner of a hospice and 50% owner of a home care provider and of a surgical center." Provider's FPP at 1.

> program payments due. These records include, but are not limited to, matters pertaining to—
>
> (i) Provider ownership, organization, and operation;
>
> (ii) Fiscal, medical, and other recordkeeping systems; . . .
>
> (vii) Costs of operation; . . .
>
> (ix) Flow of funds and working capital.

These accounting records and reports must also be capable of verification by qualified auditors. 42 C.F.R. § 413.24 requires the following in pertinent part:

> (a) *Principle.* Providers receiving payment on the basis of reimbursable cost must provide adequate cost data. This must be based on their financial and statistical records which must be capable of verification by qualified auditors. The cost data must be based on an approved method of cost finding and on the accrual basis of accounting . . . .
>
> * * * *
>
> (c) *Adequacy of cost information.* Adequate cost information must be obtained from the provider's records to support payments made for services furnished to beneficiaries. The requirement of adequacy of data implies that the data be accurate and in sufficient detail to accomplish the purposes for which it is intended. Adequate data capable of being audited is consistent with good business concepts and effective and efficient management of any organization, whether it is operated for profit or on a nonprofit basis. It is a reasonable expectation on the part of any agency paying for services on a cost-reimbursement basis. In order to provide the required cost data and not impair comparability, financial and statistical records should be maintained in a manner consistent from one period to another. However, a proper regard for consistency need not preclude a desirable change in accounting procedures if there is reason to effect such change.

With regard to substantiating reasonable costs, PRM 15-1 § 1005 similarly requires in pertinent part:

> The provider must make available to the intermediary when requested adequate documentation to support the costs incurred by the related organization, including, when required, access to the related organization's books and records, attributable to supplies and services furnished to the provider. Such documentation must include an identification of the organization's total costs, the basis

> of allocation of direct and indirect costs to the provider, and other entities served.

In proceedings before the Board, the provider carries the "burden of production of evidence and burden of proof [to] establish[], by a preponderance of the evidence, that [it] is entitled to relief on the merits of the matter at issue."[28]

**DISCUSSION, FINDINGS OF FACT, AND CONCLUSIONS OF LAW:**

***A. Provider's Position***

For FY 2015, Lindsborg was certified as a CAH and was a controlled entity of Salina Regional (consistent with 42 C.F.R. § 413.17(a)).[29] Lindsborg is a small rural hospital (25 beds), while Salina Regional operates a much larger (393 beds) regional referral center approximately 22 miles from Lindsborg. Salina Regional "was also the sole owner of a hospice, and 50% owner of a home care provider and of a surgical center."[30] Effective October 1, 2012, Salina Regional and Lindsborg entered into an Affiliation Agreement[31] and a Management and Operating Agreement with the purpose to "provide residents of the city of Lindsborg and the surrounding area with high quality care *on a more efficient basis*."[32]

Under the Affiliation Agreement included at Exhibit P-6, Salina Regional assumed responsibility for the management and operations of Lindsborg, and all Lindsborg employees, including physicians and mid-level providers, became employees of Salina Regional; however, ownership of Lindsborg was not changed and Lindsborg's Board of Directors "maintain[ed] their responsibilities for [Lindsborg]."[33] The Management and Operating Agreement sets forth the specific details of this arrangement,[34] and specifically notes that Salina Regional performed its management and operation of Lindsborg *as an independent contractor* and costs associated with its role as an independent contractor were not to be reimbursed:

> 2.6 ***Independent Contractor Relationship.*** It is expressly understood that SRHC, in performing services under this Agreement, does so as an independent contractor. The sole interest and responsibility of LCH is to see that the Management Services and Operating Services covered by this Agreement are performed and rendered in a competent, efficient, and satisfactory manner. SRHC shall be exclusively responsible for all taxes, withholding payments, penalties, fees, fringe benefits, liability premiums, contributions to insurance, pension, profit sharing or other deferred compensation plans, including but not limited to its

[28] 42 C.F.R. § 405.1871(a)(3).
[29] Provider's FPP at 1, 16-17.
[30] *Id.*
[31] *See* Exhibit (hereinafter, "Ex.") P-3 (website announcement describing the finalization of the Affiliation Agreement).
[32] Ex. P-6 (emphasis added). *See also* Provider's FPP at 1.
[33] *See* Ex. P-3. *See also* Ex. P-6, §§ 2.2, 6.2. Provider's FPP at 5.
[34] *See generally* Ex. P-6 at 22-25 (Ex. A, listing bulleted management services to be provided).

> worker's compensation and social security obligations, licensing fees, dues and assessments, and the filing of all necessary documents, forms, or returns pertinent to the foregoing.[35]

Lindsborg also retained the authority to make a number of "Major Decisions,"[36] and Salina Reginal is entitled (in its sole discretion) "to decline to take any action relating to the operation of [Lindsborg] without first receiving the express written approval of such action by the [Lindsborg] Board."[37]

While the intent is for Salina Regional to operate and manage Lindsborg using Lindsborg's own revenue, Salina Regional has the option to "provide short-term capital infusion into [Lindsborg] operations" during "brief periods of time when cash flow from [Lindsborg] operations is insufficient to meet [its] operating expenses."[38] However, in the event of such "short-term capital infusion," Lindsborg would ultimately owe these amounts *to Salina Regional*.[39] As provided in the Affiliation Agreement, Lindsborg would use "the ***intercompany*** *account*" to reimburse Salina Regional "based on *actual costs* incurred by SRHC for goods, services, and personnel involved and [would] settle[] *through the intercompany account*."[40] Salina Regional would "sweep" whatever funds were available in Lindsborg's accounts, because Lindsborg's revenues did not typically cover its expenses.[41] Salina Regional became "the records custodian for any and all past and future [Lindsborg] records,"[42] and the parties intended to both convert Lindsborg's electronic medical records ("EMR") system from its existing system to Meditech, which was what Salina Regional used, and to integrate the two facilities' EMR systems.[43] Salina Regional also has the right of first refusal to purchase Lindsborg, in the event that the hospital is sold or dissolved.[44]

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[35] *Id.* at § 2.6 (underline emphasis added and bold and italics in original).
[36] *Id.* at § 2.3.
[37] *Id.* at § 2.4.
[38] *Id.* at § 5.1.
[39] *Id.* at § 5.5. *See also, e.g.,* Provider's FPP at 6; Ex. P-8.
[40] Day 1 Tr. at 238-239 (quoting § 5.5 of the Affiliation Agreement at Ex. P-6) (emphasis added). *See also* Ex. P-6 at § 5.1 (stating: "It is understood that to the extent SRHC does infuse capital into LCH for operations or capital acquisitions, such transactions will be reflected *in the* ***Intercompany Accounts*** *described in Section 5.5*. SRHC shall keep the LCH Board advised of any needed capital infusion and the status of the *Intercompany Accounts* ***on a monthly basis***. (emphasis added)); *id*. at § 5.3 (stating: "SRHC will compensate staff providing services at LCH at competitive market rates . . . . It is understood that reimbursement to SRHC for services hereunder will be based on actual costs incurred by SRHC for goods, services and personnel involved, and will be settled *through the* ***intercompany account*** *described in Section 5.5 below*." (emphasis added); *id*. at § 5.5 (stating: "5.5 ***Intercompany Account Adjustments on Termination***. Transfers of funds between LCH and SRHC will be accounted for in a Due From/Due To account (the "Intercompany Account") that is part of the general ledger of LCH. In the event the Agreement is terminated, a debit balance in the Intercompany Account would represent a balance owed to LCH by SRHC, and a credit balance in the account would represent an amount owed by LCH to SRHC. Upon termination of this Agreement, LCH will reimburse SRHC the amount of a credit balance in the Intercompany Account. Upon termination of this Agreement, a debit balance in the Intercompany Account showing a surplus in the account would remain the property of LCH." (underline emphasis added and bold and italics emphasis in original)).
[41] Day 1 Tr. at 73-74, 155-157, 280.
[42] Ex. P-6 at § 9.1.
[43] *Id.* at § 9.2.
[44] *Id.* at § 11.

In its Final Position Paper, Lindsborg gives the following overview of its process to allocate Salina Regional's costs that were *directly attributable* to Lindsborg:

> Starting in FY 2013, Lindsborg claimed Salina Regional's costs of operating Lindsborg as allowable costs on its Medicare cost report in accordance with Medicare related party regulations. This included Lindsborg's share of the cost of services that were provided by Salina Regional to both Lindsborg and to itself.
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> . . . [I]n order to determine the costs of services to Lindsborg, Salina Regional set up separate non-allowable cost centers on its Medicare cost report for Administrative & General, Nursing Administration, Central Services & Supply, and Medical Records & Library for Lindsborg . . . . Salina Regional allocated costs that it incurred to the Lindsborg non-reimbursable cost centers using Lindsborg statistics in accordance with Medicare payment principles, including costs incurred by Salina Regional *that were directly attributable to Lindsborg*, direct nursing hours, cost requisitions, and gross revenue.
>
> As reflected on Lindsborg's FY 2015 Medicare cost report, Lindsborg claimed these amounts as related party costs on Worksheet A-8-1.[45]

Lindsborg then explains that any remaining shared costs were assigned from Salina Regional to Lindsborg without use of a specific statistic, but rather by using a *default* allocation methodology, namely allocating based on total costs.[46] As such, Salina Regional treated these remaining shared costs as indirect costs. Lindsborg contends that the Medicare Contractor recognized its related party costs for its FY 2013 and 2014 as-filed cost reports, using Salina Regional's FY 2013 and 2014 non-reimbursable cost centers. Further, Lindsborg argues that the "Medicare Contractor's *prior acceptance* of the use of non-reimbursable cost centers to determine the costs incurred by Salina Regional in furnishing services to Lindsborg was consistent with Medicare regulations, prior actions of other fiscal intermediaries, and decisions of the Board and Administrator."[47] However, Lindsborg asserts that the Medicare Contractor improperly changed its position in auditing its FY 2015 cost report.[48] In making that assertion, Lindsborg contends that the Medicare Contractor's disallowance of the related party costs at issue was based on the following findings: (1) Lindsborg "exceeded the amount Lindsborg actually incurred" and "did not reflect 'actual costs incurred'";[49] and (2) "because Salina Regional did not have an ownership interest in Lindsborg – the parties were related based solely on control - Lindsborg could not claim related party costs that were not reflected in payments to

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[45] Provider's FPP at 8 (citations omitted).
[46] *Id.* at 28. *See also* Day 2 Tr. at 9-10.
[47] Provider's FPP at 26.
[48] *Id.* at 9, 26.
[49] *Id.* at 10.

Salina Regional."[50] The Medicare Contractor's adjustments on Lindsborg's FY 2015 NPR resulted in the disallowance of $1,383,886, representing a portion of the overall related party costs claimed on the FY 2015 as-filed cost report.[51]

Lindsborg maintains that the Medicare Contractor disallowed these related party costs because it did not "pay Salina Regional an amount equal to the related party costs claimed on its Medicare cost report."[52] It further maintains that the "Medicare Contractor imposed this requirement solely because Salina Regional was related to Lindsborg based on control rather than ownership."[53] In support, Lindsborg alleges that the Medicare Contractor is relying on a new policy (posted after the relevant FY had closed) wherein it would "permit recognition of *all* related party costs claimed by a provider if the related entity that furnished the services was related to the provider through *ownership*, but recognize only lesser amounts paid by the provider to the related entity if the parties were related by *control*."[54] Lindsborg maintains there is no regulatory authority for this alleged new policy, and that "[t]he fact that Salina Regional incurred the costs of furnishing services to Lindsborg permits Lindsborg, a related entity, to include such costs in its own Medicare allowable costs. . . . [and] because Lindsborg and Salina Regional were related entities, Lindsborg complied with applicable Medicare regulations and the 'actually incurred' requirement when it claimed costs incurred by Salina Regional as its own allowable costs."[55]

Lindsborg argues that the "[a]mounts paid by a provider to a related entity, if any, are not relevant under the regulations."[56] Lindsborg further contends that the Medicare Contractor's arguments focus on the "purpose" of the relevant PRM 15-1 provisions, and did not even "attempt to demonstrate that its position was consistent with the *language* of the Medicare related party regulations."[57] Lindsborg claims that "Medicare related party regulations require a provider to claim costs incurred by a related entity that furnished services to the provider, which are considered to have been incurred by the provider."[58] Finally, Lindsborg argues that the Medicare Contractor failed to demonstrate that the claimed related party costs were unreasonable, and that the affiliation with Salina Regional was very beneficial to the hospital, which was struggling to stay open.[59]

### *B. Medicare Contractor's Position*

The Medicare Contractor maintains that it "limited the cost of [Lindsborg's] management services to the actual amount they incurred and reported on their trial balance."[60] The Medicare Contractor emphasizes that, under the Management and Operating Agreement, Lindsborg acting through its Board of Trustees:

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[50] *Id.* at 9.
[51] *Id.* at 11; Day 2 Tr. at 12, 206-209; 239-41.
[52] Provider's FPP at 17.
[53] *Id.*
[54] *Id.*
[55] *Id.* at 23, 25.
[56] Provider's Responsive Brief at 3 (Sept. 6, 2022).
[57] *Id.* at 5.
[58] *Id.* at 8.
[59] *Id.* at 8-11.
[60] Medicare Contractor's FPP at 1.

> [R]etains the rights/ authority to participate in the making of major decisions, and remains the holder of all licenses, accreditation certificates, contracts, etc. which [it] obtains, and remains the provider or supplier for medical services within the confines of all third-party contracts.[61]

The Medicare Contractor also notes that, pursuant to the management and operating agreement, Salina Regional is performing its services to Lindsborg "as an independent contractor,"[62] and that "several types of expenses [] are included in the calculation of the profit/ loss of the provider."[63] The Medicare Contractor further points out that "[t]he overhead allocations from [Salina Regional] to the provider is ***not*** mentioned *in any part of the operating contract*."[64] The Medicare Contractor also claims that the *actual* financial arrangements do not reflect those of an independent contractor.[65] The Medicare Contractor concedes that the parties are related, but concluded that Lindsborg "was only entitled to claim the costs they *actually incurred* and/or reported *on their trial balance*" for FY 2015.[66]

In support of its position, the Medicare Contractor offers the following rationale:

> The provider believes they do not need to incur all costs they are claiming for Medicare reimbursement. The MAC asserts that the provider must substantiate the services received and the related costs allocated to them from another entity for which they are claiming Medicare reimbursement in order for the MAC to determine if the costs are reasonable and necessary for delivery of patient care.
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> ****
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> The operating agreement does not state that the provider is subject to an allocation of overhead costs, for which they do not have to pay.[67]

The Medicare Contractor continues that reimbursable costs "must be reasonable and necessary,"[68] and cites 42 C.F.R. § 413.9, which states that reasonable costs are "necessary and proper costs *incurred* in furnishing the services."[69] Since Salina Regional does not have direct or indirect ownership over Lindsborg, payments from Salina Regional to Lindsborg are not "*essentially* a payment to itself," which is a justification for allowing related party costs.[70] Nor

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[61] *Id.* at 21.
[62] *Id.*
[63] *Id.*
[64] *Id.* at 21-22 (emphasis added).
[65] *Id.* at 22.
[66] *Id.*
[67] *Id.* at 24.
[68] *Id.* at 25.
[69] *Id.*
[70] *Id.* at 26 (emphasis added). *See also* PRM 15-1 § 1005 ("[t]he intent is to treat the costs incurred by the [related] supplier as if they were incurred by the provider itself.") (copy at Ex. P-29); PRM 15-2 § 4013 ("When you are dealing with a related organization, you are essentially dealing with yourself and Medicare considers the costs to you equal to the cost to the related organization.") (copy at Ex. P-30).

has Lindsborg shown that the claimed costs are reasonable representations of fair market value for the services received (*e.g.*, by providing competitive bids).

The Medicare Contractor notes that: (1) "SRHC allocation of costs to [Lindsborg], for which they never charged [Lindsborg], and [Lindsborg's] claiming of such costs for Medicare reimbursement, in effect, shifts costs that would ordinarily be reimbursed under the inpatient prospective payment system (IPPS) to a payment system, in which Medicare reimbursement is determined based on reimbursable costs" ; and (2) "This leads to enhanced Medicare reimbursement for the provider and additional revenues for SRHC, inasmuch as SRHC and the provider equally share in the provider's revenues from Medicare year-end settlements (Exhibit C-2)."[71]

Finally, the Medicare Contractor notes that, in this case, the amount Lindsborg was to pay to Salina Regional was not specified. Lindsborg merely turned over all of its revenues to Salina Regional who determined the value of the services it provided to Lindsborg.[72] In evaluating whether the A&G costs claimed were reasonable, the Medicare Contractor compared the A&G costs incurred in FY 2012 (the last fiscal year in which Lindsborg performed ***its own*** *management and operation functions*) with the A&G cost claimed in FY 2015 (the FY under appeal) after adjustments for inflation. As a result of this comparison, the Medicare Contractor determined that FY 2015's A&G costs showed an increase of 265 percent compared with FY 2012's A&G costs. The Medicare Contractor asserts that this 265 percent increase from FY 2012 to FY 2015 is not supportable. In particular, it claims that the salaries and fringe benefits associated with such an increase are not reasonable.[73] It summarizes its arguments for disallowing Lindsborg's related-party A&G costs as follows:

> If [Salina Regional] incurred costs on behalf of the Provider, for services other than those which were directly assigned/passed to the Provider during the cost reporting period, [Salina Regional] should have maintained verifiable statistical data for determining the costs of the services on a ongoing basis. The data should have been used to assign costs to a non-reimbursable cost center. In lieu of such data, [Salina Regional] and the Provider used an easy/handy statistic, the Provider's total operating costs, to allocate the Administrative and General costs of [Salina Regional] to the Provider. The MAC again asserts that there is no relationship of the Provider's total operating costs and the costs incurred by [Salina Regional], when providing services to the Provider. [Salina Regional]'s method of allocating costs implies that SRHC incurred indirect cost for every expenditure of the Provider. However, the Provider directly incurred many of its own costs without the involvement of [Salina Regional].[74]

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[71] Medicare Contractor's FPP at 28 (citing the Management and Operating Agreement).
[72]Medicare Contractor's Supplement to its Final Position Paper at 3 (Sept. 14, 2022) ("Medicare Contractor's Supplement").
[73] *Id.* at 4-5.
[74] *Id.* at 9-10.

### *C. Decision of the Board*

At the outset, the Board notes that the issue and amount of cost in dispute in this case has continually decreased throughout the proceedings due to the ever-shifting position of Lindsborg on the amount it maintains it is due. Lindsborg presented several arguments related to whether related-party costs are determined using a different methodology when the parties are related by ownership versus related by control.[75] The Medicare Contractor's audit workpapers noted that Lindsborg and Salina Regional "are related through the control provision," but it ultimately limited the allowable related party costs to those "actually incurred."[76] There is no dispute that Lindsborg and Salina Regional are related parties.[77] It is clear that certain costs incurred by Salina Regional ***directly*** related exclusively to Lindsborg (*e.g.*, certain salaries) were claimed on Lindsborg's cost report ***and*** were allowed as *direct costs* by the Medicare Contractor.[78] According to Lindsborg, these direct costs, as reported on Worksheet A, totaled approximately $7.024 million of which Medicare paid its share.[79] What is at issue in this case are A&G or other indirect costs on Salina Regional's cost report, where such costs were allegedly shared (and allocated via Salina Regional's cost report *after the fact*) between both related parties, such as human resources employees, medical records, purchasing, intellectual technology, nursing administration, and accounts payable employees who served both entities.[80]

The Board agrees with the Medicare Contractor that, pursuant to 42 C.F.R. § 413.17, Lindsborg, as a related party to Salina Regional, is permitted to claim costs which were incurred by Salina Regional on Lindsborg's behalf. CAHs are paid on a reasonable cost basis and ***reasonable*** *costs* are defined as "all necessary and proper costs ***incurred*** in furnishing the services." This definition applies to both direct and indirect costs.[81] All records used to support the allocation of *alleged* shared costs from Salina Regional's A&G to Lindsborg "must be capable of verification by qualified auditors"[82] and Lindsborg must "carr[y] its burden of production of evidence and burden of proof [to] establish, by a preponderance of the evidence, that [it] is entitled to relief on the merits of the matter at issue."[83]

Since the dispute is over how much of Salina Regional's overhead costs can be properly allocated to Lindsborg as a shared cost, the Board first looks to Lindsborg's as-filed FY 2015 cost report and how much it identified as being allocated from Salina Regional and what methodology it used to do so. The Board notes that Lindsborg has conceded that *the initial allocation* on the as-filed cost report, which was audited by the Medicare Contractor, was ***incorrect***. Indeed, Lindsborg initially claimed, *on its as-filed cost report*, $1,383,886 in related party costs, including $1,168,552 in A&G costs, incurred by Salina Regional, resulting in a claim for Medicare Payment of $826,739.[84]

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[75] Provider's FPP at 18-23.
[76] Ex. P-7 at 21. *See also* Ex. P-16 at 4.
[77] Ex. P-17 at 2. *See also* Medicare Contractor's FPP at 24.
[78] Day 1 Tr. at 12. Day 2 Tr. at 8-9, 14-16.
[79] Day 2 Tr. at 15.
[80] *See supra* note 78. *See also* Day 2 Tr. at 139-141.
[81] 42 C.F.R. § 413.9(c)(3).
[82] 42 C.F.R. § 413.24.
[83] 42 C.F.R. § 405.1871(a)(3).
[84] Provider's FPP at 8-9, 28.

Specifically, in its Final Position Paper, Lindsborg conceded that this original allocation was flawed. Accordingly, as part of its Final Position Paper, Lindsborg removed *additional* costs that it conceded were not applicable (*i.e*., unrelated) to Lindsborg and included a revised calculation that reduced the related party costs at issue by fourteen percent (14%) to $1,189,750, with a corresponding reduction in Medicare reimbursement impact to $710,762.[85] In three situations, involving nursing administration, central services, and medical records, Lindsborg reduced the original figures by assigning "costs that could be assigned to Lindsborg based upon a specific statistic"[86] via allegedly more precise allocations.[87] However, Lindsborg's new position was short-lived because, at the hearing, the Provider's witness conceded once again that *even this revised related party cost calculation is* ***incorrect***, and that other costs should be removed because they are ***not*** related to Lindsborg.[88]

As previously noted, Lindsborg carries the burden of production of evidence and the burden of proof to establish by a preponderance of the evidence that it is entitled to the relief it seeks.[89] Salina Regional's workpapers for its allocation of indirect costs to Lindsborg for the actual cost report were not submitted as part of the record in this case[90] and, as such, the Board is unable to review its original allocation methodology. Exhibit P-38 was relied upon heavily by Lindsborg's witnesses during the hearing, but this exhibit: (1) does not contain any of the workpapers that Salina Regional used in preparing the as-filed cost report or in preparing the *revised* allocations to Lindsborg in this exhibit; (2) is not an auditable document; and (3) *was only created for this appeal and reflects* ***revised*** *allocations* (*i.e*., it is not a document contemporaneous to the period at issue).[91] Accordingly, the Board cannot accept Lindsborg's allocation methodology because it is unsubstantiated. Indeed, *since the cost report was filed*, Lindsborg has revised its allocation calculations and then conceded at the hearing that the most recently submitted calculations may still have errors, or contain expenses that could be removed or allocated more specifically.[92] Thus, the Board must conclude that the claimed costs, based on the record before it, which contains no workpapers, backup support, or other detail, are unsubstantiated. Without such documentation in the record, the Board is also unable to properly ascertain what an appropriate indirect allocation *would* be.

The Board notes that, pursuant to the Management and Operating Agreement,[93] Salina would be reimbursed based on actual costs and such reimbursement would be done through intercompany account transfers[94] (but were ***not*** to include costs associated with Salina Regional's role as an

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[85] Provider's FPP at 28; Ex. P-38; Provider's Responsive Brief at 4. Examples of cost centers removed in full included security and a storage facility that Lindsborg, being in a different location, did not "share" in the underlying costs. Day 2 Tr. at 42-43. Similarly, Salina Regional's accreditation expense was removed. *Id.* at 44.
[86] Provider's FPP at 28.
[87] Provider's FPP at 28-30. Day 2 Tr. at 26-31.
[88] *See* Day 2 Tr. at 73-81.
[89] 42 C.F.R. § 405.1871(a)(3).
[90] *See* Day 2 Tr. at 28-29, 122-124.
[91] *Id.* at 122-123.
[92] *Supra* note 85 and accompanying text. In this regard, the Board notes that Lindsborg witness agreed that "a mock home office work paper would go a lot further to properly supporting expenses than using a $7 million stat." Day 2 Tr. at 120.
[93] Ex. P-6.
[94] Day 1 Tr. at 237-241. *See also* Ex. P-6 at § 5.

independent contractor[95]). In this regard, the Section 5 of the Affiliation Agreement addresses "Finances and Accounting" and states, as follows, regarding payment of costs and expenses:

> 5.1 ***Costs and Expenses in Managing and Operating LCH.*** SRCH shall manage and operate LCH for the account of LCH using the revenue of LCH to apply to the expenses of LCH operations. SRHC shall be entitled to reimbursement of reasonable costs and expenses incurred by it in the performance of its duties and responsibilities under this Agreement. This shall include salaries, fringe benefits, and expenses incurred by SRHC personnel in providing services at LCH. It is the intent and expectation of both parties that LCH will be operated by SRHC in a strategically and financially viable manner. Although it is understood that there may be brief periods of time when cash flow from LCH operations is insufficient to meet LCH operating expenses, SRHC may provide short-term capital infusion into LCH operations; provided, however, nothing herein shall require SRHC to continually infuse operating capital into LCH to continue operations at a deficit without consulting the LCH Board and the express authorization of the SRHC Board. It is understood that to the extent SRHC does infuse capital into LCH for operations or capital acquisitions, such transactions will be reflected in the Intercompany Accounts described in Section 5.5. SRHC shall keep the LCH Board advised of any needed capital infusion and the status of the Intercompany Accounts on a monthly basis.
>
> 5.2 ***Books and Records.*** The accounting records for LCH shall be maintained on an accrual basis in accordance with generally accepted accounting principles, consistently applied. SRHC agrees that the LCH accounting records and all reports based on them shall be available, upon request, at all times to the LCH Board.
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> 5.3 ***Staff Expense and Contractual Obligations*** SRHC will compensate staff providing services at LCH at competitive market rates based on salary data available from objective third patties taking into account the experience and qualifications of employees for the positions to which they are assigned. SRHC will make good faith efforts to negotiate with vendors to obtain competitive and fair market value rates for LCH. It is understood that reimbursement to SRHC for services hereunder will be based on actual costs incurred by SRHC for goods, services and personnel involved, and will be settled through the intercompany account described in Section 5.5 below.
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> 5.4 ***Financial Reporting.*** SRHC shall ensure timely preparation, filing, and the furnishing to the LCH Board the fo11owing information:

[95] Ex. P-6 at § 2.6. It is unclear if any of the shared costs at issue include costs associated with Salina Regional's role as an independent contractor.

> 5.4.1 Monthly unaudited financial statements;
>
> 5.4.2 After the close of each fiscal year a balance sheet and related statement of income and expenses for LCH for the fiscal year being reported;
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> 5.4.3 The annual IRS Form 990 shall be prepared for, and submitted to, the Board of LCH in a timely manner for approval and submission in accordance with federal law;
>
> 5.4.4 The annual cost report, as required by law as a condition of participation in the Medicare and Medicaid programs; and
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> 5.4.5 The annual audit of the year-end financial statements of LCH either standalone or combined with SRHC, by an independent certified public accounting firm and reported to the LCH Board by the auditors. SRHC may retain copies of all records prepared for and on behalf of LCH.
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> 5.5 ***Intercompany Account Adjustments on Termination***. Transfers of funds between LCH and SRHC will be accounted for in a Due From/Due To account (the "Intercompany Account") that is part of the general ledger of LCH. In the event the Agreement is terminated, a debit balance in the Intercompany Account would represent a balance owed to LCH by SRHC, and a credit balance in the account would represent an amount owed by LCH to SRHC. Upon termination of this Agreement, LCH will reimburse SRHC the amount of a credit balance in the Intercompany Account. Upon termination of this Agreement, a debit balance in the Intercompany Account showing a surplus in the account would remain the property of LCH. [96]

Significantly, no overhead/A&G expenses were ever actually claimed by Salina Regional or expensed by Lindsborg, *through the intercompany accounts* (either contemporaneous with FY 2015 or later) or on the FY 2015 balance sheet and related statement of income and expenses required in § 5.4.2 of the Affiliation Agreement.[97] At the hearing, Lindsborg's witness admitted that, unlike "actual direct costs,"[98] the Management and Operating Agreement, *when it was put together*, did not address or contemplate Lindsborg paying for overhead/A&G costs; but, nonetheless, the witness asserted that Lindsborg and Salina Regional had intended to handle, or had a "goal" of handling, Salina's indirect costs through Lindsborg's cost report process:

> When we put the agreement together, we were looking at it as an operational agreement. We were looking day-to-day operations. So our goal going in was to have control and financial risk so that we

[96] Ex. P-6 at § 5.5 (underline emphasis added).
[97] Lindsborg changed this practice for FY 2016. Specifically, for FY 2016, Lindsborg started "making an estimated monthly journal entry onto the books and records of both Salina Regional and Lindsborg to account for those shared expenses in order to have an estimate on each of our financial statements annually." Day 2 Tr. at 13. *See also id.* at 64-65.
[98] Day 1 Tr. at 239-241.

> qualified to consolidate our financial statements and operations. So when we were talking about costs, we were talking primarily about what we've been referring to as direct costs. So the revenue and expenses that go through the intercompany account are all the direct costs that relate to day-to-day operations of Lindsborg Community Hospital. *We were **not ever** **contemplating overhead shared service costs** when the agreement was put together*. . . . We knew that, or we thought we knew that, and it worked for two years that the shared costs because we had built this so related party organizations would be done on the cost report after the fact and were not contemplated at all in day-to-day operations of how this agreement worked. You know, everything we had read, everything we looked at, everything we got advice from our auditors and anyone else we talked to said, yes, the shared, related party costs are done on the cost report. *So none of that was ever contemplated* as we talked about this intercompany account in and out. I don't know if that helps or not, but ***our goal*** was we thought we knew it *was an allowable cost on the cost report*, but it was done at the time of the cost report, not every day of the week in operation.[99]

Significantly, as recognized by Lindsborg's witness, the Affiliation Agreement at Exhibit P-6 *never* discusses reimbursement of Salina Regional's indirect costs, whether through intercompany transfers or through Lindsborg's cost report process. Indeed, the Affiliation Agreement specifies: (1) in ¶ 5.2 that Lindsborg's accounting records would be maintained on an accrual basis; and (2) in ¶¶ 5.4.1 and 5.4.2 that Salina Regional would provide Lindsborg with "[m]onthly unaudited financial statements" and, "[a]fter the close of the close of each fiscal year, a balance sheet and related statement of income and expenses for [Lindsborg] for the fiscal year being reported," respectively. In this respect, the Board notes that the cost report process ***only*** pertains to reimbursement by the Medicare program and, as such, raises concerns about how the indirect costs associated with non-Medicare patients is tracked and reimbursed pursuant to the terms of the Affiliation Agreement and consistent with 42 C.F.R. § 413.5(a). Not doing so raises cost-shifting concerns because, as explained at § 413.5(a), "costs attributable to other patients of the institution are not to be borne by the [Medicare] program."[100]

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[99] *Id.* at 239-41. *See also* Day 2 Tr. at 140-141 (Provider witness agreeing that there is no obligation for Lindsborg to make a payment to Salina Regional for shared costs). Indeed, after a long back and forth with the Lindsborg's witness from Salina Regional (Day 2 Tr. at 91-109), it remains unclear what prompted Lindsborg and Salina Regional start doing monthly journal entries for estimated A&G shared costs at some point during FY 2016 (Day 2 Tr. at 108).

[100] To highlight the Board's concern from a Medicare reimbursement perspective, the Board notes that, given the fact that CAHs are required to have a transfer and referral agreement in place per 42 C.F.R. § 485.616(a)(1), failure to properly track or account for shared expenses could also potentially raise unique fraud and abuse concerns (*e.g.*, inappropriate shifting of costs as payment in exchange for patient referrals from one to the other if there are transfers and/or a transfer agreement between the two). In giving this example, the Board is not finding or suggesting that it exists here (there is no evidence in the record to support such a finding and it is beyond the normal scope of Board review) but is merely giving an example to illustrate why proper accounting is so important for Medicare reimbursement purposes. *See, e.g.,* DOJ Press Release (Jul. 21, 2022) (available at: https://www.justice.gov/usao-

The Board also looked more closely at the intercompany transfers. While direct expenses were tracked through intercompany transfers,[101] twice per month, Salina Regional would "sweep" whatever funds were available in Lindsborg's accounts because Lindsborg's revenues did not typically cover all of its direct expenses as tracked through those intercompany transfers.[102] The Medicare Contractor argues that the allocation of Salina Regional's A&G is done here merely to increase Medicare Reimbursement by moving Salina Regional's A&G costs from its IPPS payment model to Lindsborg's reasonable cost payment model, for reimbursement as a CAH.[103]

Analysis of the overall A&G costs at Lindsborg supports the Board's decision to affirm the Medicare Contractor's disallowance of the indirect costs at issue. Since indirect costs were *never* contemplated or actually expensed, in order to determine the amount of indirect costs to allocate to Lindsborg, Salina Regional used total costs as the *default* statistic.[104] Salina Regional identified Lindsborg's total cost as a percentage of Salina Regional's total costs and allocated a proportional amount of its A&G to Lindsborg. The allocation results in a high percentage of A&G costs at Lindsborg.[105] An analysis of both Lindsborg and Salina Regional's as-filed FY 2015 cost reports provided in Exhibits C-10 and C-11 shows the concern:

Per Filed FY 2015 Lindsborg Cost Report:

| | |
|---|---|
| Total A&G Costs for Allocation (W/S A, line 5, col. 7) | $2,294,063[106] |
| Total Hospital Expenses (W/S A, line 200, col. 7) | $8,413,241[107] |
| Total A&G Cost Percentage | 27.27% |

Per Settled FY 2015 Salina Regional Cost Report:

| | |
|---|---|
| Total A&G Costs for Allocation (W/S A, line 5, col. 7) | $21,778,367[108] |
| Total Hospital Expenses (W/S A, line 200, col. 7) | $194,567,117[109] |
| Total A&G Cost Percentage | 11.19% |

The calculations above indicate that, while Salina Regional's A&G costs, as a percentage of total costs (including the costs of Lindsborg) is 11.19 percent, after the allocation from Salina Regional, Lindsborg's aggregate A&G costs are 27.27 percent of its total costs. Thus, it appears that the allocation methodology creates artificially-inflated A&G costs for Lindsborg, since the cost is *almost **3 times higher*** for A&G, as a percentage of total costs, at Lindsborg than at Salina

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edtx/pr/21-charged-including-hospital-and-lab-ceos-connection-multistate-healthcare-kickback (last accessed Jul. 28, 2024)) (discussing *U.S. v. Hertzberg at al* in which "The defendants were charged for their roles in a conspiracy through which physicians were incentivized to make referrals to critical access hospitals and an affiliated lab in exchange for kickbacks which were disguised as investment returns.").

[101] Day 1 Tr. at 239-240.

[102] Day 1 Tr. at 73-74, 155-157, 280.

[103] Medicare Contractor's FPP at 28 (citing the Management and Operating Agreement).

[104] *See* Provider's FPP at 8, 28.

[105] *See* Day 2 Tr. at 223-226.

[106] Ex. C-10 at 8.

[107] *Id.*

[108] Ex. C-11 at 4.

[109] *Id.* at 5.

Regional. When A&G cost comprises over 25 percent of total costs, it automatically raises questions of reasonableness and, again, raises concerns about cost shifting.[110] Indeed, when questioned on whether "it [is] reasonable for a hospital to have 25 percent of its costs related to A&G," Lindsborg's witness conceded it was not stating: "I would say it is not reasonable" and that it would raise a concern with the reasonableness of the A&G allocation at Lindsborg.[111]

The Board finds that using Lindsborg's total costs as a statistic (*i.e*., the *default* allocation methodology) does not logically relate to or establish the amount of Salina Regional's A&G costs that were actually incurred by Salina Regional on Lindsborg's behalf. Lindborg's witness acknowledged that using Lindsborg's total costs to develop a statistic for allocation of Salina Regional's A&G costs could ***never*** *properly* allocate those A&G costs *without requiring additional material off-the-cost-report calculations*, as was done in Lindsborg's initial and revised related party cost calculations, and in Exhibit P-38.[112] This is problematic because, as happened in this case, items may be overlooked, causing the allocation to, at a minimum, be artificially inflated. Indeed, between filing its appeal and final position paper, Lindsborg reduced the allocation by removing additional items.[113] Notwithstanding this reduction, Lindsborg later acknowledged that this reduction still was not enough because, at the hearing, Lindsborg's witness admitted that even more items should be removed as discussed *supra*.[114] Lindsborg's witness also acknowledged that other statistics could be used which may be more accurate, but that they were not considered.[115]

Further confounding matters, Lindsborg was also unable to explain why it was not consistent in its allocation of A&G costs *across other related entities*. In particular, Lindsborg could not explain why it used the *default* allocation methodology of total costs as a statistic to allocate A&G costs for Lindsborg, but did not similarly use it for Salina Regional's other entities. For example, its hospice had total expenses of $1.3 million per the financial statements at Exhibit P-1, but only $141,449 were listed as its statistic for allocation of A&G on Salina Regional's cost

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[110] *See supra* note 100 and accompanying text.
[111] *See* Day 2 Tr. at 226.
[112] Day 2 Tr. at 115-116 ("[BOARD MEMBER]: Is there any possible way in which the methodology of reporting Lindsborg's total $7 million of cost on Salina [ Regional']s cost report to develop a statistic to allocate A and G to Lindsborg could ever properly allocate that A and G without making material off of the cost report calculations such as P- 38? THE WITNESS: The answer would be no.").
[113] *Supra* notes 85-87 and accompanying text.
[114] *Supra* note 88 and accompanying text. *See also supra* note 95 and accompanying text. In this regard, Lindsborg did not necessarily access shared services in the same way as other departments at Salina Regional since: (1) Lindsborg was 23 miles from Salina Regional (Day 1 Tr. at 9) where a shared service may have been located (*see, e.g.*, Day 2 Tr. at 47 discussing Chaplaincy program at Salina Regional); and (2) as a small CAH with 15 beds (Day 1 Tr. at 173), its share of shared services can be very different since it is run with limited staff (Day 2 Tr. at 62-63) and presumably can have limited and/or sporadic census and operations (particularly in comparison to Salina Regional, a 380-bed hospital). For example, Lindsborg as a CAH can only provide, on average, critical care to a patient for 96 hours while Salina Regional had no such limitation. Day 2 Tr. at 176; *see also* 42 C.F.R. § 485.620(b) (stating: "The CAH provides acute inpatient care for a period that does not exceed, on an annual average basis, 96 hours per patient."). Yet, Lindsborg had an Administrator, CFO, a Billing person, and Nurse Administrator (Day 2 Tr. at 58-59; Day 1 Tr. at 129) and also provided some accounting and medical records functions (Day 2 Tr. at 80; Day 1 Tr. at 128-29). Finally, Lindsborg's witness was unable to explain discrepancy between Worksheet A total amount of 22,214,152.79 and the balance of 24,103,822.29 to allocate as listed in Ex. P-38 at 3-4. Day 2 Tr. at 76-77.
[115] Day 2 Tr. at 116-117.

report per Revised Exhibit P-9.[116] Again, Lindsborg is entitled to claim costs incurred on its behalf by its related party, Salina Regional, but *it is Lindsborg's burden to establish what the* ***reasonable*** *allocation amount is* and this disparate treatment confirms its allocation methodology was not reasonable. Accordingly, the Board concurs with the Medicare Contractor that, based on the record, Lindsborg has failed to establish a reasonable allocation methodology for the alleged shared costs at issue.

Even if the Board were to accept that Lindsborg's most recent calculations and statistics represent the indirect costs actually incurred by Salina Regional on behalf of Lindsborg, the Board is not persuaded by the record that these indirect costs can be considered reasonable under the prudent buyer principle at PRM 15-1 § 2103. Reasonable costs are costs actually incurred,[117] and those which were necessary and proper, meaning "appropriate and helpful in developing and maintaining the operation of patient care facilities and activities."[118] Providers are expected to minimize their costs as any prudent (*i.e.*, reasonable) buyer would.[119] Prudent buyers do not pay excessive costs for services, and Medicare Contractors routinely compare "prices paid by providers to the prices paid for similar items or services by comparable purchasers."[120] This principle is reiterated in the specific context of related party costs in the regulations and the Provider Reimbursement Manual, as well, which state that "such cost must not exceed the price of comparable services . . . that could be purchased elsewhere."[121]

Consistent with the prudent buyer principle, one of the stated purposes of the Affiliation Agreement,[122] Management and Operating Agreement,[123] and the general arrangement between Lindsborg and Salina Regional was "to reduce operating expenses."[124] While the arrangement did envision efficiencies in shared services, Lindsborg's day-to-day operations of the hospital remained unchanged; Lindsborg staff simply became Salina Regional staff and continued operating the hospital as it had been.[125] Indeed, questioning during the hearing indicated that the alleged indirect costs at issue relate, in part, to Salina Regional staffing/services that appear to otherwise duplicate (in whole or in part) staffing/services already at Lindsborg itself.[126] For example, by allocating the alleged shared costs based on the total costs, it is assumed that the level of services provided to Salina Regional's own departments, such as Admissions, Collections, Nursing Administration, etc. is equal to the level of services provided by those same departments to Lindsborg. But how can that be when Lindsborg ***already*** has staffing to perform some or all of those similar duties on its behalf? Either the assumption has no basis or the arrangement, rather than reduce costs, as intended by the arrangements between the hospitals, increased the costs. Indeed, the cost report indicates that Lindsborg's costs increased

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[116] *Id.* at 83-85, 112. *See also* Ex. P-1 at 18; Revised Ex. P-9 at 14. There was also a similar issue identified with the home medical services partnership. Day 2 Tr. at 87-88.
[117] 42 U.S.C. § 1395x(v)(1)(A).
[118] 42 C.F.R. § 413.9(2).
[119] PRM 15-1 §§ 2102.1, 2103.
[120] *Id.* § 2103.
[121] 42 C.F.R. § 413.17(a); PRM 15-1 § 1000.
[122] *See* Ex. P-3 (website announcement describing the finalization of the Affiliation Agreement).
[123] Ex. P-6.
[124] Ex. P-6 at "Recitals #4(2)."
[125] *See supra* note 33 and accompanying text. *See also infra* note 126 and accompanying text.
[126] Day 1 Tr. at 127-130.

significantly. From FY 2012, the year prior to when Lindsborg and Salina Regional entered into their management agreement, to FY 2015 which is the FY at issue in this case, Lindsborg's A&G costs appear to have risen 165 percent,[127] as shown below.

| | |
|---|---|
| Lindsborg FY 2012 A&G Net Expense (w/s A, line 5, col. 7) | $ 866,027[128] |
| Lindsborg FY 2015 A&G Net Expense (w/s A, line 5, col. 7) | $2,294,063[129] |
| Increase from FY 2012 to 2015 | $1,428,036 |
| Percentage of Increase | 164.90% |

The above calculation further supports the Board's earlier concern that A&G expenses (after allocation from Salina Regional), as a percentage of total costs at Lindsborg, are not reasonable and not consistent with the prudent buyer principle.[130]

To further highlight how unreasonable Lindsborg's aggregate A&G costs are, the Board notes that Lindsborg's A&G costs *drastically* ***increased*** between 2012 and 2015, *notwithstanding the fact that the FTEs and individuals employed at Lindsborg generally remained the same* after Lindsborg entered into its arrangement with Salina Regional.[131] Comparing prices paid by Lindsborg itself at two different times is a reasonable starting point in evaluating the reasonableness of a cost. Lindsborg paid 165 percent more for A&G services in FY 2015 than it paid for similar services in FY 2012. This increase occurred notwithstanding the fact that Lindsborg's full time employees remained approximately the same following the Salina Regional affiliation.[132] It also occurred despite the fact that Lindsborg's partnership with Salina Regional resulted in higher productivity and effectiveness for Lindsborg's operations.[133] While increased revenue may account for some degree of increased costs, as suggested by Lindsborg,[134] any attempt to illustrate this was far too imprecise to state with confidence that the Medicare Contractor's determination of reasonableness was improper.

While the Board understands that A&G costs may not remain static, it cannot dismiss the Medicare Contractor's concerns that a 165 percent increase in overall A&G costs in comparison to FY 2012 (as adjusted for inflation), and an overall A&G allocation that represents over 25 percent of Lindsborg's total costs is unreasonable. Accordingly, based on the use of total costs as an allocation statistic and the deficiencies in creating that statistic outlined above (including the lack of sufficient auditable supporting documentation in the record),[135] the Board finds that

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[127] Medicare Contractor's Supplement at 4-5; Ex. C-10 (FY 2012 A&G Net Expense on Worksheet A, Line 5, Column 7 = $866,027; FY 2015 A&G Net Expense on Worksheet A, Line 5, Column 7 = $2,294,063. $2,294,063 divided by $866,027 = 264.90 percent.) (The Medicare Contractor's calculation reflects that FY 2015's costs were 265 percent of FY 2012's costs, which is an increase of 165 percent.)

[128] Ex. C-10 at 3.

[129] Ex. C-10 at 8.

[130] Indeed, consistent with the prudent buyer principle, 42 C.F.R. § 413.17(a) specifies that related party costs "must not exceed the price of comparable services, facilities, or supplies that could be purchased elsewhere"; however, Lindsborg did not provide any documentation on the price of comparable services to confirm it was a prudent buyer. Day 1 Tr. at 251-54.

[131] *See* Day 1 Tr. at 114-115, 136-137.

[132] Day 1 Tr. at 114-15.

[133] Day 1 Tr. at 118, 131-134.

[134] Day 2 Tr. at 52.

[135] *Supra* notes 46, 104-05.

Lindsborg has failed to substantiate that the shared and A&G costs claimed are reasonable consistent with its burden of production of evidence and burden of proof at 42 C.F.R. § 405.1871(a)(3).[136] In affirming the Medicare Contractor's disallowance, the Board again notes that it is clear that certain costs incurred by Salina Reginal ***directly*** related exclusively to Lindsborg (*e.g.*, certain salaries) were claimed on Worksheet A of Lindsborg's cost report (consistent with the terms of the Affiliation Agreement) and were allowed as *direct costs* by the Medicare Contractor. Here, the Board affirms the disallowance of the indirect costs for which Lindsborg's witness admits both that "[w]*e* were ***not ever*** contemplating overhead shared service costs when the [Affiliation A]greement was put together. . . ."[137] and there is no obligation for Lindsborg to make a payment to Salina Regional.[138]

## DECISION:

After considering Medicare law and regulations, the arguments presented, and the evidence admitted, the Board finds that the Medicare Contractor's disallowance of the related party costs claimed by Lindsborg for FY 2015 was proper.

## BOARD MEMBERS PARTICIPATING:

Clayton J. Nix, Esq.
Kevin D. Smith, CPA
Ratina Kelly, CPA

## FOR THE BOARD:

8/9/2024

X Clayton J. Nix

Clayton J. Nix, Esq.
Chair
Signed by: PIV

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[136] *See Lancaster Hosp. Corp. v. Becerra*, 58 F.4th 124, (4th Cir. 2023) ("Lancaster asserts that—even if some reduction were warranted—the Board erred by denying its entire 1997 reimbursement request. There appears no doubt Lancaster provided services to Medicare beneficiaries in 1997 and denying all reimbursement for that year may seem harsh. But the principle that people "must turn square corners when they deal with the Government" "has its greatest force when a private party seeks to spend the Government's money." *Heckler v. Community Health Servs. of Crawford Cnty., Inc.*, 467 U.S. 51, 63, 104 S.Ct. 2218, 81 L.Ed.2d 42 (1984). "As a participant in the Medicare program," Lancaster "had a duty to familiarize itself with the legal requirements for cost reimbursement," *id*. at 64, 104 S.Ct. 2218, including the need to provide cost data in a form "capable of being audited," 42 C.F.R. § 413.24(c).3 The Board's decision to deny reimbursement for fiscal year 1997 was neither arbitrary nor capricious and was supported by substantial evidence. The district court's judgment is thus AFFIRMED.")

[137] Day 1 Tr. at 239-41.

[138] Day 2 Tr. at 140-141 (Lindsborg's witness agreeing that there is no obligation for Lindsborg to make a payment to Salina Regional for shared costs).