CENTERS FOR MEDICARE AND MEDICAID SERVICES

Decision of the Administrator

IN THE CASE OF:	CLAIM FOR:
Rush Presbyterian- St. Luke's Medical Center	**Medicare Reimbursement Fiscal Year Ending: 06/30/92**
Provider	
vs.	**REVIEW OF:**
Blue Cross Blue Shield Assn./ AdminiaStar Federal - Kentucky	**PRRB Dec. No. 2007-D13 Dated: January 19, 2007**
Intermediary	

This case is before the Administrator, Centers for Medicare&Medicaid Services (CMS), for review of the Provider Reimbursement Review Board's (Board) decision. The review is during the sixty-day period mandated in §1878(f)(1) of the Social Security Act (Act) [42 USC 1395oo(f)(1)], as amended. Comments were received from the Provider, the Intermediary, and the Centers for Medicare Management (CMM). The Administrator notified the parties of his intent to review the Board's decision. The Provider submitted further comments. Accordingly, the Board's decision is now before the Administrator for final administrative review.

ISSUE NO. 1 AND BOARD DECISION

Issue No. 1 is whether the Provider's transplant surgery residents should be included in the full-time equivalent (FTE) count for the purposes of both direct graduate medical education (GME) and indirect medical education (IME) reimbursement.

The Board found that Congress required the Secretary to establish which programs would be approved and which bodies would approve them. The implementing regulation at 42 CFR 413.86(b) defines an approved residency program for cost reporting periods beginning on or after July 1, 1985. Based upon the plain meaning of 42 CFR 413.86(b), the regulation in effect during the cost year at issue, the transplant surgery fellowship was not a specifically-allowed medical subspecialty. The Board found that, neither the Accreditation Council for GME (ACGME), nor

the American Board of Medical Specialties (ABMS), had recognized transplant surgery as a medical subspecialty in the period under appeal. Thus, the Board found that the transplant surgery program of the Provider was not an approved medical residency program and time spent by program fellows was not includable in the GME or IME FTE counts.

ISSUE NO. 2 AND BOARD DECISION

Issue No. 2 is whether the Provider was entitled to reimbursement under 42 CFR 405.523 for the costs it incurred for its transplant surgery fellowship residents.

The Board found that the transplant program meets the requirements of a non-approved educational program under section 405.523. Thus, the Board held that the Provider's incurred salary and salary-related fringe benefit costs for the transplant surgery fellowship residents were allowable under section 405.523, and remanded the issue to the Intermediary to review the costs under that regulation.

ISSUE NO. 3 AND BOARD DECISION

Issue No. 3 is whether the Intermediary, in calculating the Provider's Disproportionate Share Hospital (DSH) payment, should have included all of the Medicaid Health Maintenance Organization (HMO) days, as reported by the Illinois Department of Public Aid (IDPA).

The Board stated that 42 CFR 413.20 and 413.24 require providers to present adequate documentation to support Medicare costs. In this regard, the Board noted that the Intermediary accepted 39 of the 172 MedCare HMO days based upon sufficient documentation. However, the Intermediary maintained that its experience with using IDPA reports for HMO day purposes has resulted in a high incidence of errors. Thus, the Intermediary required eligibility screens for all MedCare HMO claims reported on the IDPA's listing. Based upon its review of the record, the Board found that the Provider's IDPA documentation, without support of MedCare HMO eligibility screens, was insufficient to make a determination of its accuracy. Therefore, the Board concluded, the Provider failed to meet its burden of proof imposed by 42 CFR 413.20 and 413.24, and the Board affirmed the Intermediary's adjustment.

ISSUE NO. 4 AND BOARD DECISION

Issue No. 4 is whether the Intermediary's disallowance of a portion of the depreciation expense claimed for the Provider's Atrium Pavilion was proper.

The Board found that there was no dispute regarding the facts relating to this issue. Both parties agreed that the Pavilion depreciation should have ceased by FYE 06/30/92. Moreover, both parties recognized that an error occurred in the depreciation calculation when the Provider changed the useful life of the Pavilion calculation from a composite life to a component-based life. The Board found that the Intermediary was technically correct in disallowing the extra depreciation claimed by the Provider in FYE 06/30/92. The Board explained that the proper action would have been to reopen prior year cost reports, but this was not possible due to the expiration of the three-year limitation imposed in the regulations. However, the Board found that, based on the Provider's claim, the Intermediary routinely allowed multi-year adjustments in one cost reporting period. This usually involved circumstances where it adjusted depreciation that benefited Medicare and the procedure was performed out of administrative convenience. Thus, based on these circumstances, the Board found that the Intermediary should have allowed the Provider's remaining unclaimed and un-reimbursed depreciation, and reversed the Intermediary's adjustment.

SUMMARY OF COMMENTS

ISSUE NO. 1

The Provider requested reversal of the Board's decision on Issue No. 1 on the basis that the Board ignored the statute in favor of exclusive reliance on the regulations. The Provider explained that, examining all of the evidence, the Administrator must find that the Provider's transplant surgery fellowship program met the definition of an approved program. The Provider points to 42 CFR 413.85(b) and finds that this regulation supports a finding that their program is approved. The Provider also points to an Administrator decision in Ellis Hospital, PRRB Dec. 98-D31, in support of its position. Moreover, the documentation in the record indicated that the program was a residency program and that participation counted toward the specialty of transplant surgery.

ISSUE NO. 2

The Intermediary requested that the Administrator review the Board's decision for Issue No. 2 for two reasons. First, the Board concluded, without justification, that a program which is not qualified for reimbursement under 42 CFR 413.86 is automatically entitled to reimbursement under 42 CFR 405.523. Second, the Board's suggestion that the Provider submitted a claim which was capable of audit was incorrect. An identification of specific resident services to the Medicare beneficiaries had to be the initial inquiry. The Intermediary explained that it has

always been willing to evaluate such documentation to determine the accuracy of the claimed costs, but the Provider has never submitted it.

CMM commented and explained that it did not dispute that residents should be able to bill for their services under the regulations, but residents may be reimbursed under Part B only if timely bills are submitted, which was not done in the instant case. Thus, CMM concluded that the Provider was not entitled to Medicare Part B reimbursement for services furnished by the Provider's transplant surgery fellows in FY 1992.

The Provider argued for the Board's decision on Issue No. 2 be upheld. The Administrator is bound to apply all laws and regulations in reviewing the Board decision. The Provider stated that as it claimed the FTEs in its GME resident count, it did not provide that data in its cost report as a claim under 42 CFR 405.523 as an non-approved program. In addition, the Provider could not know which interns and residents the intermediary would ultimately disallow on audit. Therefore, the Board's remand to determine that accuracy of claimed costs under 42 CFR 405.523 is appropriate and should be affirmed.

ISSUE NO. 3

The Provider contended that it furnished documentation of 172 Medicaid HMO days for inclusion in its DSH calculation. The source of the documentation was a public report from the State Medicaid agency that was reported by the Medicaid HMO, not by the Provider. The Provider further argued that the Intermediary was unable to prove that these days should not be included in the DSH calculation. The Provider observed that the Intermediary confirmed that at least 39 of the 172 days were allowable. However, the Provider argued, another test of the data verified that 148 of the 172 days were also valid. In sum, the Provider contended that the Board's finding was unsupported by law or fact, and must be reversed, or, at a minimum, modified to allow those days that were clearly supported in the record.

In further comments, the Provider noted that the consulting firm provided substantial evidence that the 172 days were in fact understated. In addition, there is no evidence that the Provider did not provide at least 172 days of care to Medicaid HMO patients. In fact, the Provider alleged that there was virtually no chance that the claim for 172 days is overstated as there was no reason for MedCare to report more days that actually paid; many of these days were tested and found valid; and all of the claims were valid for which corroborating evidence was found.

ISSUE NO. 4

The Intermediary argued that there is clear precedent that the Board's order constituted a prohibited practice.[1] The Provider simply did not report its depreciation correctly and, thus, the adjustment should be sustained.

The CMM disagreed with the Board's decision on Issue No. 4. According to the matching principle, CMM stated that including a cost in a year where it does not belong does not reflect a proper matching of costs and revenues in that period. CMM maintained that the Intermediary's adjustment to remove excess depreciation was correct. If the Provider had timely requested reopening of the prior cost reports to claim the unclaimed depreciation, the Intermediary could have considered the Provider's request, as permitted in 42 CFR 405.1885. In reversing the Intermediary's adjustment, the Board required the Intermediary to ignore Medicare reimbursement principles, and directed the Intermediary to include the pre-1992 costs in the FYE 1992 cost report for the purpose of "'administrative consistency.' " Thus, CMM recommended that the Administrator overturn the Board's decision on Issue No. 4.

The Provider claimed it was entitled to depreciation expense for the Pavilion. The Provider argued that the Intermediary acknowledged that the depreciation expense was understated in one or all of the previous years. The only issue is whether an unclaimed portion of such expense can be claimed in FYE 1992. The Provider stated that it is clear that the Medicare program will receive a windfall in that it did not recognize the full amount of the Provider's reimbursable expenses. The Provider argued that it is clearly entitled to claim all of its depreciation expense for the Pavilion on its Medicare cost report. While the Intermediary and CMM maintains that the "matching principle" will be violated if the Board's holding is upheld, that argument is contradicted by the Intermediary's own actions and by the fact that there is no reimbursement effect in allowing the Provider's claim to the depreciation account balance. If depreciation expense is not allowed in this case, the result will be an inaccurate finding of cost. Accurate information concerning the depreciation expense for the Pavilion now exists and the Board's decision accurately reflects it.

[1] The Intermediary cited to Illinois Telephone Cost Group Appeal, PRRB Dec. No. 79-D41 and Ravenswood Hospital, PRRB Dec. No. 79-D58.

DISCUSSION

Applicable to all of the issues in this case, the entire record furnished by the Board has been examined, including all correspondence, position papers, exhibits, and subsequent submissions. All comments timely received have been considered and included in the record.

ISSUE NO. 1

The direct GME payment is set forth at Section 1886(h)(5)(A) of the Act, which defines an approved medical residency training program, in relevant part, as a residency, or other postgraduate medical training program, participation in which may be counted toward certification in a specialty or subspecialty and includes formal postgraduate training programs in geriatric medicine "approved by the Secretary. " (Emphasis added.) In addition, Section 1886(d)(5)(B) explains that an indirect medical education (IME) adjustment will be made in the same manner as the adjustment was made prior to the implementation of the inpatient prospective payment system.

The Secretary addressed the implementation of the new GME provisions of section 1886(h) of the Act in light of the existing definition set forth at section 1861(b) of the Act and the status of fellowship programs in early years. In particular, the Secretary stated that:

> Section 1886(h)(5)(A) of the Act sets forth a new definition of an approved medical residency program that largely resolves any question about the status of these fellowship programs in past years. It defines an approved medical residency program as "a residency or other postgraduate medical training program participation in which may be counted toward certification in a specialty or subspecialty ****." Thus, for purpose of determining direct GME costs, Congress has shifted the emphasis from the accreditation of the program to the acceptability of the training for the purpose of attaining certification in a specialty or subspecialty. Further, the internal medicine subspecialty programs are now individually accredited by the ACGME.
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> However, section 1886(h)(5)(A) of the Act did not change the existing reference in section 1861(b)(6) of the Act with respect to approved programs. Therefore, we were faced with the rather complicated situation of having two statutory definitions of an

> approved residency program for cost reporting periods beginning on or after July 1, 1985. We propose to resolve this matter by defining an approved program as a residency program in medicine, osteopathy, dentistry or podiatry that is approved by one of the national accrediting bodies set forth in section 1861(b)(6) of the Act or that may be counted toward certification in a medical specialty or subspecialty cited in the 1985-1986 Directory of Residency Training Programs. Furthermore, any fellowship program that meets the requirements of an approved program in geriatric medicine as defined by the Secretary will also be included in this definition.[2]

The implementing regulation for the GME payment is set forth at 42 CFR 413.86 (1992)[3] and 42 CFR 412.105 (1992) for IME payments. Those regulations essentially have the same requirements with respect to defining an "approved" program. Consistent with his statutory authority, the Secretary has promulgated regulations that define an approved medical residency program as a program that is approved by one of the national organizations listed in section 42 CFR 405.422 (1992)[4] or may count towards certification of the participant in a specialty or subspecialty listed in the Directory of Graduate Medical Education Programs or the Annual Report and Reference Handbook, or is approved by the ACGME as a fellowship program in geriatric medicine.

In this case, the Provider conceded that its transplant surgery fellowship program was approved only by the American Society of Transplant Surgeons. That approval body is not listed in the above referenced regulations at 42 CFR 413.86(b) or 42 CFR 412.105. The American Society of Transplant Surgeons also is not listed as one of the national approval organizations in 42 CFR 405.422,[5] cited in both regulations above. Further, the fellowship program does not count towards certification of the participant in a specialty or subspecialty listed in the above cited publications. Rather, the record indicates that transplant surgery experience is incorporated in, and a requirement of, other specialties such as general surgery.[6] Accordingly, as the transplant surgery fellowship program was not an approved program for purposes of Medicare payment under 42 CFR 413.86(b) and 42 CFR 412.105, it was proper for the Intermediary to remove the related FTEs from both

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[2] 54 Fed Reg. 40286 (September 29, 1989).
[3] Redesignated as 42 CFR 413.75.
[4] Redesignated as 42 CFR 415.152.
[5] Redesiganted as 42 CFR 415.152.
[6] See, e.g., Intermediary I-5.

the GME and IME FTE counts.[7] Thus, the Board's decision on Issue No. 1 is affirmed.

ISSUE NO. 2

With respect to reimbursement for the reasonable cost of the Provider's transplant surgery fellowship residents, the regulation at 42 CFR 405.523 (1992)[8] establishes, in relevant part, the following:

> (a) The services of a hospital resident or intern who is not under an approved teaching program in the hospital are reimbursable to the hospital on a cost basis under the supplementary medical insurance program. For purposes of this section, such services shall be deemed to include services of a physician employed by the hospital who is authorized to practice only in a hospital setting. Even where such services are rendered to inpatients, the cost of the services is not an allowable cost under the hospital insurance program but is allowable under the supplementary medical insurance program.
> (b) In this connection reimbursement under the health insurance program for services discussed in paragraph (a) of this section will be to the hospital in an amount of 80 percent of the cost of services rendered to the beneficiaries after recognition of the deductible....

In the preamble to the final rule implementing the GME payment of section 1886(h) of the Social Security Act, the Secretary explained that:

> Under section 405.523, hospitals are paid under Part B for up to 80 percent of the reasonable costs of services (that is, salaries and salary-related fringe benefits) of interns and residents who are not in approved programs, after payment of the Part B deductible by the Medicare beneficiary. No other educational program costs (that is, faculty compensation costs and other direct and indirect program expenses) in connection with such residents are payable.[9] (Emphasis added.)

In addition, a general principle of cost reimbursement at Section 1815(a) of the Act provides that:

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[7] The Administrator also notes that, contrary to the Provider's comments, the Board analyzed the issue in relation to both the statute and regulation.
[8] Redesignated as 42 CFR 415.202.
[9] 54 Fed. Reg. 40286, 40295 (Sep. 29. 1989).

> the Secretary shall periodically determine the amount which should be paid under this part to each provider of services with respect to services furnished to it ...except that no such payments shall be made to any provider unless it has furnished such information as the Secretary may request in order to determine the amounts due such provider under this part for the period with respect to which the amounts are being paid or any prior period. (Emphasis added.)

Consistent with the statute, the regulation at 42 CFR 413.20(a) provides that:

> The principles of cost reimbursement require that providers maintain sufficient financial records and statistical data for proper determination of costs payable under the program.... Essentially the methods of determining costs payable under Medicare involve making use of data available from the institution's basic accounts, as usually maintained, to arrive at equitable and proper payment for services to beneficiaries.

Moreover, 42 CFR 413.24(a) states that:

> 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 Provider in this case has claimed that it incurred costs for employing the transplant surgery fellows, including salary and fringe benefits.[10] The Administrator first finds that this claim was never presented to the Intermediary or placed on the cost report. The Provider does not claim it would have been futile to have claimed these costs, but rather argues that it could not claim payment twice for the same interns and residents as the Provider elected to claim the FTEs for purpose of its GME/IME payment. While Board jurisdiction has not been raised and briefed on this issue, the record shows that the Provider cannot demonstrate that it meets the "dissatisfaction" criteria for Board jurisdiction. The Provider never claimed these intern and resident Part B reasonable costs on its cost report and cannot argue that it have been futile for it to do so. Rather, the failure to claim these costs as Part B reasonable costs was because it elected to count the FTEs as part of its GME/IME payments.

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[10] See Provider's Position Paper at 10, ff.

The Provider claims that it could not have known that the FTEs would have been excluded from the GME and IME payments. The Administrator finds that the Provider acknowledged that the fellowship program was only recognized by the American Society of Transplant Surgeons and, thus, on its face under the regulation, the Provider was on notice that it was not a recognized approved program, but elected nonetheless to pursue payment under the GME/IME methodology.

In addition, once it was before the Board, the Provider raised this issue as an alternative argument, but the Provider again did not present documentation for the Board's consideration to support its claim for these costs. The Provider had sufficient opportunity in briefing this issue to supply the necessary documentation in the record to support its late claim, but it failed to do so. As the Provider has been presented with sufficient opportunity to submit this documentation, both before the Intermediary and the Board, a remand to the Intermediary is not appropriate. Consequently, the Administrator finds that the Provider has failed to meet its burden for payment of the costs under 42 CFR 405.523. Thus, the Board's decision on Issue No. 2 is reversed.

ISSUE NO. 3

The Intermediary pointed out that the Provider obtained a listing from the IDPA which contained days submitted by the MedCare HMO to the State. The Administrator finds that the IDPA listing did not support a finding that the days submitted by HMOs were accurate and contained only Medicaid eligible days. Thus, the Intermediary was proper to require a review of the days on any HMO listings to verify that only Medicaid eligible days were included on the listing.

Notably, the listing, which is in the record, contained no names or patient identifiers. The listing included only dates and lengths of stay. The Intermediary asked the Provider to match dates of stay from the MedCare HMO list to the patient's financial and/or medical files as well as provide documentation from the IDPA indicating that the patient was eligible for Medicaid during the dates of stay on the MedCare HMO listing. The Provider furnished the patient financial file and eligibility documentation matching dates of stay for only 39 of 172 days. Without further documentation showing a matching of dates of stay with financial files and showing proof that the patients were eligible for Medicaid during their stays, the Intermediary was proper not to accept the remaining 133 days. The Administrator finds that the record does not include the necessary documentation to support the additional 133 days. Thus, the Provider failed to meet its burden of proof under section 1815 of the Act and 42 CFR 413.20 and 413.24 to document its MedCare HMO days for its DSH calculation. The Intermediary properly adjusted the

Provider's claimed HMO days downward from 172 to 39 days. Accordingly, the Board's decision as to Issue No. 3 is affirmed.

ISSUE NO. 4

As noted above, the Section 1815(a) of the Act provides that: "no such payments shall be made to any provider unless it has furnished such information as the Secretary may request in order to determine the amounts due such provider under this part for the period with respect to which the amounts are being paid or any prior period. (Emphasis added.) Consistent with the statute, 42 CFR 413.20 and 413.24 set forth the general documentation and accounting requirements. As noted above, the regulations at 42 CFR 413.20 and 413.24 require that providers maintain adequate financial records and statistical data for the accurate determination of costs reimbursable under Medicare. The process of determining such reimbursable costs involves the review of data available from the provider's usually-maintained accounts to arrive at the proper payment amounts for services to beneficiaries. In addition, 42 CFR 413.24(f) (1992) states that, for cost reporting purposes, the Medicare program requires each provider of services to submit periodic reports of it operations that generally cover a consecutive 12-month period of the provider's operation.

Pursuant to the reasonable cost provision of section 1861(v)(1)(A) of the Act, the Secretary promulgated regulations on the payment of capital costs, including payment for depreciation. Generally, the payment of depreciation is based on the valuation of the depreciable assets used for rendering patient care as specified by the regulation. The regulation at 42 CFR §413.130 explains, *inter alia*, that:

> (a) *General rule.* Capital related costs ... are limited to:
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> (1) Net depreciation expense as determined under §§413.134, 413.144, and 413.149, adjusted by gains and losses realized from the disposal of depreciable assets under 413.134(f).

The regulation at 42 CFR 413.134 states that: "an appropriate allowance for depreciation in buildings and requirement used in the provision of patient care is an allowable costs. The depreciation must be- (1) identifiable and recorded in the provider's accounting records; (2) based on the historical costs of the asset....; and (3) prorated over the estimated useful life of the asset...." using one of three methods.

The regulation at 42 CFR 413.134(b)(2) explains, for example, that if the straight line method is used:

> the cost or other basis ... of the asset, less its estimated salvage value, if any, is determined first. Then this amount is distributed in equal amounts over the period of the estimated useful life of the asset. "[11]

Further, 42 CFR 413.134 (c) states that the:

> [a]ppropriate recording of depreciation includes the identification of the depreciable assets in use, the assets' historical costs, the assets' dates of acquisition, the method of depreciation, estimated useful lives, and the assets' accumulated depreciation.

Under the Medicare program, consistent with the generally Medicare cost matching principles reflected above, depreciation expense is distributed as a cost to the Medicare program over the period of the estimated useful life of the asset. And thus, depending upon the method used, a certain prorated amount of the depreciation expense is allocated to specific cost years.[12]

This issue involves depreciation expense related to the Provider's Atrium Pavilion. The Pavilion had a ten-year useful life assigned to it for depreciation purposes.[13] Based upon the ten-year life beginning in FYE 06/30/82, the Pavilion should have become fully depreciated during FYE 06/30/92, the cost year at issue. However, the Provider changed the methodology it used to calculate depreciation expenses from the composite method to the component method for the Atrium Pavilion during the

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[11] The Provider Reimbursement Manual further explains at section 116.1 the various aspects of calculating depreciation expense noting that under the straight line method for example, "the annual allowance is determined by dividing the costs of the asset (less any estimated salvage value) by the years of useful life. This method produces a uniform allowance each year."

[12] In addition to the Medicare cost matching principles, the Supreme Court in Guernsey v. Shalala, 514 U.S. 87 (1995), also recognized the importance of timing in allowing costs, noting that: "Proper reimbursement requires proper timing. Should the Secretary reimburse in one year costs in fact attributable to a span of years, the reimbursement will be determined by the provider's Medicare utilization for that one year, not for later years. This leads to distortion. If the provider's utilization rate changes or if the provider drops from the program altogether the Secretary will have reimbursed up front an amount other than that attributable to Medicare services."

[13] See Provider's Position Paper at pp. 14-17 and the Intermediary's Position Paper at pp. 14-18.

ten year period.[14] The component depreciation method allows individual parts of a building to be separately depreciated. At the end of FYE 1992, there was an excess balance remaining in the Pavilion depreciation account, due to what the parties point to as a depreciation calculation error. However, the Provider claimed this depreciation expense, alleged to be attributable to earlier cost years, as an increase to allowable depreciation expense for the FYE 1992 cost year.

The Intermediary reviewed the Atrium Pavilion depreciation expense claimed on the FYE 1992 cost report and found that the amount claimed was greater than one full year's worth of depreciation expense for the Pavilion. Thus, the Intermediary offset the difference between one full year's worth of depreciation expense and the total depreciation amount claimed on the cost report for the Atrium Pavilion.

Applying the above law to the facts of this issue, the Administrator finds that the Provider failed to meet the documentation requirements of Section 1815 of the Act and 42 CFR 413.20 and 413.24 to demonstrate that the costs at issue were properly claimed for the FYE 1992. The parties in fact agree that the additional depreciation expense claimed is not related to the FYE 1992 cost year. The Administrator finds that there is no authority to allow the payment of costs relating to an earlier cost year in the FYE 1992 cost year.[15] Thus, the Intermediary properly disallowed the excess depreciation claimed for this cost year.[16]

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[14] The Provider claimed that the Intermediary approved the componentized depreciation method for FYE 06/30/84 for the Pavilion. See P-17. But that letter does not refer to the Pavilion. The Provider letter of November 9, 1983, requesting authorization to change depreciation method was not included in the record.

[15] Further, even Section 1878 of the Act recognizes this cost matching principle. A provider may request a hearing before the Board under section 1878(a)(1)(A)(i) if such provider is "dissatisfied with a final determination of the organization service as its fiscal intermediary.... as to the amount of total program reimbursement due the provider for the items and services furnished to individuals for which payment may be made under this title for the period covered by such report." Although the Board jurisdiction has not been raised with respect to this issue, the claiming of these costs in this period circumvents the Provider's failure to have properly requested and claimed in the earlier period(s) all the costs for which it believe it was entitled to reimbursement. While the Provider may be "dissatisfied" with its reimbursement, its dissatisfaction is not for the program reimbursement for which "payment which may be made under this title for the period covered by the cost report."

[16] See also section 2304 of the Provider Reimbursement Manual; Woodruff Community Hospital, PRRB Dec. No. 82-D112 (Board found costs claimed in year error discovered, rather than year when expenses incurred, not reimbursable).

DECISION

ISSUE NO.1

The Administrator affirms the decision of the Board on Issue No. 1.

ISSUE NO.2

The Administrator reverses the decision of the Board on Issue No 2.

ISSUE NO.3

The Administrator affirms the decision of the Board on Issue No. 3.

ISSUE NO.4

The Administrator reverses the decision of the Board on Issue No. 4.

THIS CONSTITUTES THE FINAL ADMINISTRATIVE DECISION OF THE SECRETARY OF HEALTH AND HUMAN SERVICES.

Date: 3/16/07

/s/
Herb B. Kuhn
Acting Deputy Administrator
Centers for Medicare & Medicaid Services