**BOARD OF TAX APPEALS**
**STATE OF LOUISIANA**
**LOCAL TAX DIVISION**

**IASIS GLENWOOD**
**REGIONAL MEDICAL CENTER, L.P.,**
**TAXPAYER**

**DOCKET NO. L00033**

**CITY OF MONROE**
**TAXATION AND REVENUE DIVISION**
**RESPONDENT**

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**JUDGMENT ON MOTION FOR NEW TRIAL AND REASONS**

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On April 15, 2021, this matter came before the Board for hearing on the *Motion for New Trial* filed by Iasis Glenwood Regional Medical Center, L.P. (the "Taxpayer"), with Local Tax Judge Cade R. Cole presiding. Present at the hearing were Kelsey Clark, Nicole Gould Frey, and David Cassidy on behalf of Taxpayer, and Drew Talbot on behalf of the City of Monroe, Taxation and Revenue Division (the "Collector"). After the hearing, the matter was taken under advisement. The Board now issues this Judgment in accordance with the attached reasons.

IT IS HEREBY ORDERED, ADJUDGED AND DECREED that the Taxpayer's *Motion for New Trial* IS HEREBY DENIED.

Judgment rendered and signed in Baton Rouge, Louisiana, this 7 day of April, 2022.

FOR THE BOARD:

LOCAL TAX JUDGE CADE R. COLE

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## REASONS FOR JUDGMENT ON MOTION FOR NEW TRIAL

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On April 15, 2021, this matter came before the Board for hearing on the *Motion for New Trial* filed by Iasis Glenwood Regional Medical Center, L.P. (the "Taxpayer"), with Local Tax Judge Cade R. Cole presiding. Present at the hearing were Kelsey Clark, Nicole Gould Frey, and David Cassidy on behalf of Taxpayer, and Drew Talbot on behalf of the City of Monroe, Taxation and Revenue Division (the "Collector"). After the hearing, the matter was taken under advisement. The Board now issues the attached Judgment in accordance with the following reasons.

This matter is an appeal from refund denials concerning Taxpayer's bulk purchases of prescription drugs ("Cardinal Drugs"), implants ("Patient Specific Implants"), medical supplies invoiced to patients ("Chargeable Medical Supplies"), and medical supplies that were used in patient care but not billed on specific patient invoices, like cotton swabs and bandages ("Non-Chargeables"). In its original Judgment the Board ruled against Taxpayer on all four categories, but explained how refunds may be possible with sufficient proof on some items. Taxpayer's Motion

for Trial asks the Board to reconsider its prior decision as to the Cardinal Drugs, Patient Specific Implants, and Chargeable Medical Supplies, but not Non-Chargeables.

The core issue is still a dispute over whether Taxpayer's bulk purchases were made "under the provisions of Medicare," and were thus excluded from sales and use tax under La. R.S. 47:301(10)(u) (the "Medicare Exclusion" and used inclusive of related Medicaid provisions). In the reasons accompanying the original Judgment, this Board explained that the Medicare Exclusion could potentially apply to a Medicare provider's bulk purchases. Contrary to the Collector's position, the Board does not interpret *Crowe v. Bio-Medical Application of Louisiana, LLC*, 14-0917 (La. App. 1 Cir. 6/3/16), 208 So.3d 473, *adhered to on reh'g*, 2014-0917 (La. App. 1 Cir. 2/17/11); 241 So.3d 328, *and writ denied*, 2017-0502 (La. 5/12/17); 219 So.3d 1106, to foreclose this possibility. However, for the Medicare Exclusion to apply to a bulk purchase between the Medicare provider and a wholesale supplier, the claimant must meet the evidentiary challenge of connecting the items purchase to their administration on a Medicare patient.

Taxpayer did not track items purchased in bulk at the level of an individual item. Thus, Taxpayer would not be able to show the Board that any one individual stent that was purchased as part of box of a dozen, or dozens of, stents was actually administered to a Medicare patient. In fact, Taxpayer did not track even the box of stents once it was purchased. Although the Board is sympathetic to the logistical burden, the Taxpayer presumably could have produced patient billing statements showing that

a stent was billed to a patient—and then cumulated the number of items subjected to tax that went to Medicare patients. Without individual billing statements, except for three examples provided out of a population of thousands of patient bills, the Taxpayer devised a formula to approximate the portion of its purchases that were administered to Medicare patients.

At trial, Taxpayer's formula was a ratio of its gross charges to Medicare patients over its gross charges to all patients. The ratio was based on Taxpayer's books and accounting records. However, the billing statements in the record show that the gross amount billed to patients included charges for non-taxable services and other unrelated charges. Charges for services, like physical therapy, are not germane to the items at issue in the refund claim. Their presence in Taxpayer's formula is a distortion that makes it unreliable. In rejecting Taxpayer's ratio, the Board suggested correcting this distortion by segregating line items billed into uniform subcategories and determining the revenue ratio for each particular subcategory.

Taxpayer now offers a more refined basis for its revenue ratio and additionally asks that the Board exercise its discretion and grant a new trial to allow new evidence. As preliminary matter, the Board will not grant a new trial on a discretionary basis. La. C.C.P. art. 1973 affords trial courts wide, but not unlimited, discretion to grant a new trial. *Lawson v. Mitsubishi Motor Sales of Am., Inc.*, 2005-0257, p. 30 (La. 9/6/06), 938 So.2d 35, 55-56. There ought to be "good and compelling reasons" to grant the motion. *See Bond v. City of Baton Rouge*, 129 So.2d

887, 893 (La. Ct. App. 1961). The movant should be able articulate why a new trial is needed to prevent a miscarriage of justice. *See Lamb v. Lamb*, 430 So.2d 51 (La. 1983). Allowing a litigant to "introduce new testimony that was clearly available during the original trial" is not a good reason for a new trial. *See Rosenkrantz v. Baton Rouge Psychological Associates*, 94-2340, p. 8 (La. App. 1 Cir. 6/23/95), 657 So.2d 1353, 1357.

Taxpayer has not provided a good reason for a discretionary new trial. Taxpayer alleges that it could have provided more specific Cardinal Drug data that tracked drug revenue by patient and insurance type. Taxpayer has not explained why it could not have introduced this evidence at trial, so there is not a compelling basis for a new trial.

As an additional preliminary concern the Board will rule on the Collector's motion to strike, as incorporated into the Collector's opposition to Taxpayer's *Motion for New Trial*. The Collector takes issue with Taxpayer's Exhibits A, B, and C. Exhibits A and B demonstrate Taxpayer's new refund calculation methodology with data that is already in the record. These Motion to Strike is denied as they are merely demonstrative material and not direct evidence. Exhibit C contains an invoice from Cardinal Drug. Taxpayer already introduced the same document as Exhibit 5 at the merits hearing. Exhibit C is not new evidence and the motion to strike is denied.

The other component of Taxpayer's argument for a new trial is brought under La. C.C.P. art. 1972(1), which requires a new trial when the verdict or judgment appears clearly contrary to the law and the evidence.

Taxpayer has re-formulated its refund claim based on revenue data from the CMS Reports already in the record. Data on the CMS Reports is organized by cost centers in varying contexts throughout hundreds of pages of forms and worksheets. According to Taxpayer, the cost center "Medical Supplies Charged to Patients" represents items that fit in the refund claim categories for Chargeables and Patient-Specific Implants. Taxpayer additionally asserts that the "Drugs Charged to Patients" cost center is interchangeable with its Cardinal Drugs refund claim category.

Taxpayer's focus on the "Medical Supplies Charged to Patients" and "Drugs Charged to Patients" cost centers makes good sense based on the plain meaning of those words. However, the Taxpayer's assumption is that the CMS Report is not a technical document with specially defined technical terms. There are a number of cost centers into which the costs of purchasing the refund claim items could have fallen: "General Service," "Inpatient Routine" services, "Ancillary" services (which include "Medical Supplies Charged to Patients" and "Drugs Charged to Patients"), and "Outpat[ient] service," "Central Services & Supply," "Pharmacy," "Adults & Pediatrics," "Intensive Care Unit," "Neonatal Intensive Care Unit," "Nursery," "Operating Room," "Recovery Room," "Delivery Room & Labor Room," "Anesthesiology," "Radiology-Diagnostic," "Cat Scan," "Endoscopy," "Laboratory Blood Storing, Processing & Trans," "Respiratory Therapy," "Physical Therapy," "Electrocardiology," "Renal Dialysis," "Diabetes Treatment Center," and "Emergency" cost center. Consequently, the Board will assess Taxpayer's new methodology in light

of the guidance provided by the Medicare's Provider Resource Manual ("PRM") and in view of the CMS Report as a whole.

Taxpayer's new formula can be split into two parallel approaches, one based on expenses and the other based on revenue. Both new formulas use data taken from the CMS Reports. First, the Board will consider the expense-based approach. This approach is more complex, and as explained below, the less reliable of the two. The expense-based approach begins with reported "direct" expenses of a CMS cost center. On Worksheet A, these "direct" expenses are actually listed under a column opaquely described as "other." The only illumination on what "other" means is that it is not "salaries."

Taxpayer then sets aside the direct expenses and extracts another number which it describes as the "fully burdened" expenses from Worksheet C, Part I. The CMS Report lists this figure under the column header "Total Costs." These "total," or "fully-burdened," costs apparently are the "other" costs, with adjustments, plus "salaries" and a pro-rated allocation of overhead, capital, and other expenses. Taxpayer divides these "total" costs by the previously extracted "other" costs. The resulting quotient is a factor (as opposed to a ratio).

Taxpayer then sets that factor aside and extracts "Total patient" revenue and a cost-to-charge ratio, also reported on Worksheet C, Part I. Setting this too aside, the Taxpayer draws the Board's attention to Worksheet D, Part IV and a sum of revenue figures described there in the columns "Inpat[ient] Prog[ram] Charge" and "Outpat[ient] Prog[ram] Charge." Taxpayer claims that this sum represents "Medicare combined

inpatient and outpatient" revenue. Taxpayer then multiplies this total "Medicare" revenue sum by the cost-to-charge ratio. Taxpayer continues by further multiplying the product by the previously derived "factor." Taxpayer calls the resulting product the "Medicare" costs. Finally, Taxpayer divides that product by the "other" cost from Worksheet A. The final ratio is what Taxpayer calls a "Medicare" cost ratio.

The above cost-based methodology is unsatisfactory. There is no certainty that the cost centers that Taxpayer is using are actually the cost centers where the expenses for the items in the refund claim were actually reported. For example, why would Cardinal Drugs expenses be reported as "Drugs Charged to Patients" and not as "Pharmacy?" Both cost centers have an expense column described as "other." For "Drugs Charged to Patients," Taxpayer claims that "other" expenses are the expenses of directly purchasing drugs. There are "other" expenses for "Pharmacy" that could mean the same thing. Further, guidance on reporting expenses from the PRM contradicts Taxpayer's argument. For Worksheet A (Taxpayer's "direct" expense data) the PRM describes "Medical Supplies Charged to Patients" as:

> [L]ow cost medical supplies **generally not traceable to individual patients**. Do not include high cost implantable devices on this line. This amount is generally not input on Worksheet A, but rather allocated to this cost center on Worksheet B from cost center 15 (central service and supply) based on the recommended statistic of costed requisitions. PRM § 3610.

These expenses are not for "Chargeables" or "Patient-Specific Implant," they are "Non-chargeables."

Taxpayer's witness who prepared the CMS Reports did not settle the question. At trial, he testified that the costs of items in the refund claim could have been reported anywhere on the CMS Reports.

The CMS Reports' revenue data, is more reliable than the expense data. First, the potentially conflicting cost centers "Central Services and Supply" and "Pharmacy" are not present on Worksheet C, Part I, where revenues are reported. The PRM's instructions for "Medical Supplies Charged to Patients" cost centers for purposes of revenue reporting are:

> Enter on each cost center line the total inpatient and outpatient gross patient charges including charity care for that cost center. Include in the appropriate cost centers items reimbursed on a fee schedule (e.g., DME, oxygen, prosthetics, and orthotics). DME, oxygen, and orthotic and prosthetic devices (except for enteral and parental nutrients and intraocular lenses furnished by providers) are paid by the Part B carrier or the regional home health intermediary on the basis of the lower of the supplier's actual charge or a fee schedule. Therefore, do not include Medicare charges applicable to these items in the Medicare charges reported on Worksheet D-4 and Worksheet D, Part V. However, include your standard customary charges for these items in total charges reported on Worksheet C, Part I. This is necessary to avoid the need to split your organizational cost centers such as medical supplies between those items paid on a fee basis and those items subject to cost reimbursement. PRM § 3620.1.

The above instructions can be summarized as requiring that revenue reported as Medicare revenue must not include certain revenues which are reimbursed by entities other than Medicare. However, the instructions also require these revenues to be included in revenue data that is not just for Medicare but for all patients.

Taxpayer reported revenue from Medicare patients for "Medical Supplies Charged to Patients" and "Drugs Charged to Patients" on Worksheet D-4, lines 55 and 56, Columns 2 and 3. The relevant guidance

in the PRM for these items only covers "Drugs Charged to Patients," and instructs: "Line 56--Enter only the program charges for drugs charged to patients that are not paid a predetermined amount." PRM § 3624. The PRM does not explain what drugs are "paid a predetermined amount."

The Taxpayer's CMS-based approach could be viable. In this case, however, the missing factual link is the absence of corroboration from the Taxpayer's record-keeping showing that Taxpayer reported data on the Cost Centers as it claims. That does not mean that the Taxpayer had to introduce all of its accounting records into evidence. Had the Taxpayer's witness not equivocated on where in the CMS Report the data for the items in question was reported, then his testimony, if not contradicted by opposing facts, could be adequate to establish how the Taxpayer reported data.

Of course, as the Board pointed out at trial, the ideal evidence to connect items purchased with Medicare patients would be Medicare patient billing statements showing the actual items used on Medicare patients. That could be cumulated and the tax on those items could be reclaimed.

Taxpayer has advocated its revenue-based approximation for all categories of items. However, for Patient-Specific Implants, Taxpayer could have made its case with patient-specific documentation. The law requires that certain implants be tracked by serial number and patient name in case of a recall. Taxpayer presumably had the invoices and billing statements showing the device serial number, and if the patient was covered by Medicare. Had Taxpayer introduced those documents as

evidence, the purchases of Patient Specific Implants for Medicare patients could have been proven to be excluded from taxation.

As explained in the above discussion of Taxpayer's request for a discretionary new trial, Taxpayer had alternative evidentiary means to prove its case with respect to Cardinal Drug. According to Taxpayer, there were detailed reports available listing the drug name, the amount administered, the charging physician, and the charge amount, and most importantly the type of insurance covering the patient. If Taxpayer had introduced the described Cardinal Drug documents with calculated summaries, then the purchases of Cardinal Drugs for Medicare patients would have been proven to be excluded from taxation.

For the foregoing reasons, the Board denies Taxpayer's Motion for New Trial. Taxpayer's revenue-based methodology based on CMS data could be successful in a future case with more closely related ancillary supporting evidence. Furthermore, alternative, more convincing documentary proof would be available in other cases for the Cardinal Drug and Patient Specific Implants categories.

Baton Rouge, Louisiana, this 7 day of April, 2022.

FOR THE BOARD:

LOCAL TAX JUDGE CADE R. COLE