IN THE MATTER OF:
THE 1979 HOSPITAL RATE APPEAL
OF ELMER COMMUNITY HOSPITAL

Decided November 7, 1979

Initial Decision

SYNOPSIS

After rejecting a "global rate" of per diem reimbursement for purposes of Blue Cross and governmental purchases of health care services and after finding the "administrative payment rate" inadequate, Elmer Community Hospital filed an appeal of its established reimbursement rates.

The administrative law judge assigned to the case determined that the hospital was asking for approval of additional costs in three "centers": policy finance benefit costs, fiscal costs, plant costs and for relief of the base period challenge in the emergency room cost center. The judge determined that the hospital failed to sustain its burden of proof for improvement in each of the three areas and accordingly denied the change in established reimbursement rates.

Charles Lee Harp, Jr., Esq., for Elmer Community Hospital (Archer, Greiner & Read, attorneys)

Peter T. Manzo, Assistant Deputy Public Advocate, Division of Rate Counsel (Stanley C. Van Ness, Public Advocate, attorney)

SPRINGER, ALJ:
This matter concerns the calculation of the 1979 per diem reimbursement rate for purposes of Blue Cross and governmental purchasers of health care services from Elmer Community Hospital ("Hospital") located in the Borough of Elmer, Salem County, New Jersey. Under the Health Care Facilities Planning Act of 1971, N.J.S.A. 26:2H-1 et seq., the Department of Health (“Department”) has adopted a cost containment program designed to carry out the stated public policy to foster health care services “... of the highest quality, of demonstrated need, efficiently provided and properly utilized at a reasonable cost.” All hospitals in New Jersey are required to follow a uniform system of cost reporting as set forth in the
Standard Hospital Accounting and Rate Evaluation Manual ("SHARE Manual"). Types of services are broken down into particular functional categories, known as "cost centers", which are carefully defined in the SHARE Manual.

Each year the Commissioner of Health, with the approval of the Health Care Administration Board, issues temporary regulations which explain the criteria used to determine the reasonableness of proposed hospital budgets. Those regulations for the 1979 budget year, entitled the 1979 Hospital Rate Review Program Guidelines ("1979 Guidelines"), were promulgated in November 1978 as N.J.A.C. 8:31-17.1 et seq.

Procedurally the case arose as follows: On or before October 31, 1978 the Hospital furnished to the Department its 1979 budget submission on forms prescribed by the SHARE Manual. Every hospital is entitled to accept a reimbursement rate (designated the "global rate") which incorporates an automatic increase over its prior rate without any special showing that such increase is justified. Having rejected this "global rate", on February 13, 1979 the Hospital was offered a "proposed alternative rate" of $138.79 per diem determined in accordance with the 1979 Guidelines. On March 26, 1979 representatives of the Hospital met with a departmental rate analyst to conduct a detailed review of the rate determination. As a result of this detailed review, on May 21, 1979 the Department issued an "administrative payment rate" of $141.27 per diem. Within 30 days after notification of the administrative payment rate, the Hospital filed an appeal from this decision and the matter was transmitted to the Office of Administrative Law for determination as a contested case pursuant to N.J.S.A. 52:14F-1 et seq.

The Hospital is asking for approval of an additional $65,000 in the policy fringe benefits cost center, for $27,000 in the fiscal cost center, for $9,000 in the plant cost center and for relief of the base period challenge in the emergency room (physicians) cost center. When examining the Hospital's budget request, it should be remembered that the policy declaration of the Health Care Facilities Planning Act emphasizes cost-efficiency. As noted by the New Jersey Supreme Court,

... The State is not concerned with encouraging quality health care that is unneeded, inefficiently provided, underutilized and not reasonably priced. The paramount objective of the Act is to promote only those "highest quality" health care services that are justifiable in a cost-benefit sense. The certificate of need
program accomplishes this goal by placing a direct check on proposed expansion programs. *N.J.S.A.* 26:2H-7 to 11. The rate review program, *N.J.S.A.* 26:2H-5, -18, attempts to achieve this goal through the more difficult process of manipulating and influencing the incentives in the third-party reimbursement mechanism so that health care providers are rewarded for cost-efficient and penalized for cost-extravagant behavior. *In re 1976 Hosp. Reimbursement Rate for Kessler Mem. Hosp.*, 78 *N.J.* 564, 583 (1979). (concurring opinion).

This legislative purpose is reflected in the stated objectives of the hospital rate review program, which are to require hospitals to establish the reasonableness of costs currently incurred and also the reasonableness of any increases in those costs. 1979 *Guidelines* (at page G-1). Once the Department establishes that a particular cost has been flagged as questionable, the burden of proof rests with the Hospital to fully justify in terms of dollar value or otherwise the benefit which will be derived from the proposed expense. 1979 *Guidelines* (at page G-12). For the sake of clarity and convenience, an analysis of the testimony, proposed findings of fact and conclusions of law will be discussed for each individual cost center involved.

**Policy Fringe Benefits**

Pursuant to the SHARE Manual, policy fringe benefits are defined as the cost center pertaining to “the cost of all employee benefits granted by an institution policy, excluding pension costs” (at page B-73). It includes all fringe benefits which a hospital elects to give its employees, such as Blue Cross/Blue Shield and major medical benefits, as distinguished from employee benefits required by law, such as social security and unemployment contributions. Legal changes are defined as “changes required to implement legislation or other mandates...” (at page E-20). Similarly, management changes are defined as “changes due to management decisions...” (at page E-20). In this cost center, the Hospital originally sought legal and management changes involving the upgrading of its employee hospitalization and medical insurance program at a cost of $66,000 per year above the amount approved by the Department. During the course of the hearing, the Hospital revised its request downward to $65,000 per year to conform to its own mathematical analysis based upon this lower figure.

To explain its reasons for disallowing the Hospital’s request, the Department called Joseph E. Currie, the rate analyst who conducted the detailed review. He testified that policy fringe benefits are a
component part of the "fringe factor" which is applied across-the-board to each individual cost center to adjust for non-salary benefits. Any increase in this fringe factor must be less than the "economic factor" of 7.25 percent. Figures supplied by the Hospital itself show that the request for policy fringe benefits exceeds by $66,000 the amount permitted by application of the economic factor. As his authority for disallowing this excess, Currie cited Section 9B of the 1979 Guidelines (at page G-16) which provides:

In establishing reimbursement rates, the Commissioner subscribes to the view that determination of compensation rates is a management prerogative. Accordingly, the Commissioner is taking the position that compensation increases in excess of the economic factor should be made only through improved utilization of personnel, upgrading of the quality of employees, increases in productivity, and other cost containment efforts.

Simply put, Currie contended that there is no provision under the 1979 Guidelines for legal and management changes in the policy fringe benefit cost center. To support his interpretation of the Guidelines, Currie referred to Schedule C (page 11 of 12) of the 1979 Budget Submission marked into evidence where the space ordinarily reserved for legal and management changes has been crossed out in the policy fringe benefit cost center. Instead, the Hospital must enter any proposed increases for this cost center under the heading "cost rate" changes. Such increases will be allowed up to the amount of the economic factor after which, Currie explained, the excess will be allowed only to the extent that the Hospital achieves savings in the various cost centers by means of improved productivity and the other cost-cutting measures suggested in the provision of the Guidelines quoted above. Since no discretion is allowed under the Guidelines, the Department does not conduct any review as to whether the cost of policy fringe benefits of one hospital is high or low in comparison to others. If a hospital does have a low fringe factor, Currie argued, it would have a correspondingly lower unit cost in each individual cost center which would allow greater expenditure in those separate areas where the Department conducts its peer group analysis.

1The economic factor is an industry-wide figure intended to compensate the Hospital for inflationary trends based on recognized standard measures such as the wage price index and the consumer price index. See SHARE Manual, Section 1.
John H. Wisda, Administrator of Elmer Community Hospital, discussed why the Hospital needs more funds in this cost center. Previously the Hospital was behind most other hospitals in furnishing health insurance to its own employees. Until recently, the Hospital only provided Blue Cross/Blue Shield “500 series” coverage, which was the lowest form of coverage available and has been discontinued by Blue Cross/Blue Shield except for preexisting groups. Employees with families were given a “single” contract so that they would have to make payroll deductions out of their own salaries if they wished coverage to extend to their dependents. No major medical insurance whatsoever was provided by the Hospital to its employees. Other hospitals in the South Jersey area were far more generous in protecting the health of their workers, offering full family coverage together with major medical as well as prescription plans and dental programs. Illustratively, a chart prepared by the Hospital shows that Millville, Newcomb, Underwood, Salem and Bridgeton hospitals all provided more extensive medical benefits. Using data gathered by the Department, the Hospital’s Controller calculated that the Hospital’s 1978 fringe rate was 91.4 percent of the median and 83.1 percent of the challenge limit for this cost center. Out of 17 Southern Jersey hospitals, the Hospital determined that it ranked 16th lowest in magnitude of the fringe rate. Consequently, Wisda indicated, the Hospital was placed at a serious competitive disadvantage in attracting and keeping personnel. In Wisda’s opinion, fringe benefits are the second item that prospective employees will look at when deciding whether to accept a job, coming right after amount of monetary compensation in importance. Since the Hospital tries to pay salary or wages equivalent to other hospitals, the relative attractiveness of fringe benefits could be a significant factor in recruitment. Fringe benefits are not subject to taxes and therefore the Hospital would have to pay workers much more per hour to achieve the same after-tax advantage that an increase in fringe benefits would bring. Although Wisda could not give any specific examples of employees who left because of low fringe benefits, he felt that persons shopping for a job would go elsewhere to obtain better benefits. Due to the shortage of nurses, Wisda worried that the Hospital would be unable to interest qualified applicants in joining its nursing staff.

As early as 1976, nurses on the Hospital staff had petitioned for expanded health coverage. These complaints were forwarded to the Personnel Committee which for two years explored various ways of alleviating the problem. Among the alternatives considered by the
Personnel Committee were quotations from commercial insurers other than Blue Cross/Blue Shied and self-insurance under a program sponsored by the New Jersey Hospital Association. Commencing in 1979, the Board of Trustees for the Hospital decided that Blue Cross/Blue Shield coverage of employees would be increased from the "500" to the "750 series", that major medical would be afforded all employees to cover the cost of catastrophic medical care and that the Hospital would pick up 80 percent of the tab for family coverage. On cross-examination, Wisda admitted that if the Hospital were allowed to increase its compensation package, it would result in a higher unit cost in those cost centers which are already high. For example, the 1978 unit cost in the acute care unit, consisting largely of nurses' salaries, is already just under the challenge limit. Any substantial increase in fringe benefits could cause the unit cost for acute care to exceed the challenge limit.

Another Hospital representative, Thomas B. Mervine Assistant Administrator since October 1976, echoed many of the points made by Wisda. In some of the departments under Mervine's supervision, departing employees had given inadequate fringe benefits as the reason for leaving. At least five or six former employees cited this deficiency as one of the motivating causes for transferring jobs and two employees had said it was their sole reason. As administrator responsible for personnel activities, Mervine was personally involved in investigating other medical insurance possibilities. Many of the commercial insurers refused to even submit quotations unless the Hospital also wanted to purchase other business such as life insurance and pension plans from the same company. Disappointingly, a long-awaited quotation from the self-insurance program of the New Jersey Hospital Association turned out to be higher than existing premiums because of an unusually large claim experienced by the Hospital in the prior year. Referring to a 1978 salary survey marked into evidence, Mervine testified that the Hospital used this document to determine its competitive position in relation to salaries paid by other hospitals. He emphasized that salaries for registered nurses and licensed practical nurses were somewhere in the middle range. From the document itself, however, it appears that the Hospital is near to the bottom in salary levels for most remaining job titles.

As its last witness on this cost center, the Hospital called its Controller, Robert W. McNamara, to explain the significance of certain documents he had prepared. He verified that the grouping of 17 hospitals in the Camden-Burlington area used to develop the statistics
in the Hospital's appeal document was identical to the Department's own geographic grouping for purposes of equalizing salaries in 1979. His chart in that document was designed to show the relationship between the Hospital's fringe percentage and those of comparable institutions in the same locality. Furthermore, McNamara introduced a chart intended to portray the impact on various cost centers if the Hospital were allowed to increase its policy fringe benefits. In essence, this exhibit shows what the results would have been if the Hospital had spread its request for an increase in policy fringe benefits throughout the various cost centers instead of concentrating the request in this single cost center. Most of the figures on the chart are either already a matter of record or mathematical computations made from such information, with the exception of Column 5 which is a revised fringe percentage based on the amount requested rather than the amount allowed. By comparing the figures in Column 12 with those in Column 14, McNamara asserted, it can be determined whether the proposed increase would cause the revised unit cost to exceed the challenged limit.

McNamara further stated that the Department has devised certain conglomerations of related cost centers known as "clusters". According to McNamara, the SHARE system does not penalize a hospital for exceeding the challenge limit in a particular cost center provided that the unit cost for the entire cluster remains under the cluster challenge limit. McNamara observed that the revised unit cost in the acute care unit cost center does exceed the challenge limit. Even taking the cluster which includes acute care as one of its components, the total revised unit cost would still exceed the cluster challenge limit. Nonetheless, McNamara added, both of the other two clusters on his chart remain under the challenge limit. Therefore, McNamara concluded, if the fringe increase were granted the Hospital would suffer a challenge in only one of three clusters. Although the Department was given a two week period within which to submit written comments on any errors on the chart, it did not take advantage of this opportunity to supplement the record.

After a careful review of the documentary evidence and the testimony regarding this cost center, I FIND the following facts:

1. Policy fringe benefits are a component part of the fringe factor which is applied across-the-board to salaries or other compensation in each individual cost center to adjust for nonsalary benefits.

2. As the Department interprets the 1979 Guidelines any increase
in the fringe factor must be less than the economic factor of 7.25% unless it can be achieved by savings through improved productivity or other cost-cutting measures.

3. A 1979 budget submission by the Hospital included a request for an increase in policy fringe benefits which exceeds by $66,000 (subsequently reduced to $65,000) the amount permitted by application of the economic factor.

4. Until the current year, Millville, Newcomb, Underwood, Salem and Bridgeton hospitals all had more extensive programs of medical benefits for its employees than the program provided by the Hospital.

5. Among 17 Southern Jersey hospitals, the Hospital’s 1978 fringe rate was 91.4 percent of the median and it ranked 16th lowest in terms of magnitude of its fringe rate. (Note: The claim that the Hospital’s fringe rate was 83.1 percent of the challenge limit is expressly rejected based on the Department’s testimony that a peer group analysis is not conducted in this particular cost center.)

6. As a result of its inadequate medical insurance program, the Hospital was placed at a competitive disadvantage in attracting and retaining qualified personnel, especially nursing staff. Prospective employees would be likely to choose hospitals where the fringe benefits were greater. Five or six employees left employment by the Hospital because of its low fringe benefits.

7. If the proposed increase in the policy fringe benefits were granted, the unit cost in the acute care unit would exceed the challenge limit. Similarly, the unit cost of the cluster which includes acute care would also exceed the challenge limit.

Based on the facts adduced at the hearing and the applicable law, I CONCLUDE that the Hospital has not sustained its burden of proving the reasonableness of its budget request in this cost center. In the course of argument, the Hospital’s counsel indicated that is attack was not against the analyst’s decision but rather against the Department’s failure to provide any mechanism whatsoever for consideration of increases in policy fringe benefits. Implicit in this position is recognition that the analyst correctly applied the regulations as written. Accordingly, the narrow issue is whether the regulations themselves are valid. Administrative regulations properly within the scope of delegated authority are entitled to a presumption of reasonableness and the Hospital has the burden of rebutting that presumption. In re 1976 Hosp. Reimbursement Rate for Elizabeth General
Hosp., (N.J. App. Div., A-4569-79, January 24, 1979) (unreported); City Consumer Services, Inc., v. Dept. of Banking, 134 N.J. Super. 588 (App. Div. 1975), certif. den., 69 N.J. 73 (1975); Cooper River Convalescent Center, Inc. v. Dougherty, 133 N.J. Super. 226 (App. Div. 1975). Especially in such a complicated and highly technical field, a wide degree of flexibility must be accorded to departmental health experts in carrying out the legislative mandate to control rising hospital costs. In re 1976 Hosp. Reimbursement Rate for Kessler Mem. Hosp., supra, at 578 (concurring opinion). Prior to adoption by the Commissioner of Health, these regulations were subject to the approval of the Health Care Administration Board consisting of representatives of medical and health care facilities and services, labor, industry and consumers of health care services. N.J.S.A. 26:2H-18. Essentially this rule-making function is quasi-legislative in nature and the resulting regulations have the full force and effect of law. State v. Atlantic City Electric Co., 23 N.J. 259 (1957); Rutgers Council v. N.J. Bd. Higher Ed., 126 N.J. Super. 53 (App. Div. 1973). As such, the 1979 Guidelines are binding upon the trier-of-fact unless it can be clearly demonstrated that they are arbitrary and unreasonable or that they contravene controlling statutory or constitutional requirements.

Contrary to the Hospital's assertion, the 1979 Guidelines do make provision for increases in policy fringe benefits. Section 9B treats such matters as a management prerogative. Fringe benefits can be automatically raised to the extent of the economic factor. Any increase beyond that point depends upon cost-saving measures initiated by the Hospital. In other words, a hospital can pay more to its workers if it is able to economize in other areas. Unlike certain costs relatively beyond a hospital's control such as the price of fuel or malpractice insurance, a hospital has far greater bargaining power in determining the total package of compensation it will give to its own employees. It is not at all arbitrary or unreasonable for a cost-containment system to insist that a hospital use its influence to keep down expenses wherever realistically possible. Proofs offered by the Hospital focused on its own perceived need for increased expenditure and not any alleged deficiencies in the regulatory scheme. But the fact that most other hospitals were able to offer superior health programs only highlights that it can indeed be done within budgetary constraints. By its own proof, the proposed increase would cause the Hospital to rise above the challenge limit in one cluster and in the acute care unit. None of the evidence presented by the Hospital is persuasive that the
regulation, on its face or as applied to these facts, should be declared invalid as a matter of law.

Fiscal

Fiscal is defined as the cost center pertaining to "all of the accounting activities of an institution" including patient billing and receivables, data processing, payroll, accounts payable and general ledger (SHARE Manual at page B-59). In this cost center, the Hospital originally sought legal and management changes involving an office manager costing $15,000 per year, a secretary costing $7,000 and a computer system costing $50,000 per year. Subsequently, the Hospital revised its request for the computer system downward to $27,000 for the half year beginning on July 1, 1979. At the detailed review, the Department allowed the first two requests for $15,000 and $7,000 so that the amount remaining in dispute is the third request for $27,000.

On behalf of the Department, Currie explained its reasons for disallowing the Hospital's request. Utilizing the data contained on the first page of a computer print-out introduced into evidence, Currie gave the Department's analysis of the 1979 budget submission. Basically, the Department makes its independent evaluation of what would be a reasonable cost by adding certain adjustments to the 1978 costs and then compares that result with the amount budgeted by the Hospital for 1979. Such analysis starts with a figure known as the "1978 projected actual covered inpatient costs" (or "1978 CIP"). Since Blue Cross only reimburses for inpatient as distinguished from outpatient services, the starting figure is expressed in terms of covered inpatient costs. It is called a "projected actual" figure because it was calculated in mid-1978 and represents a composite of the then available actual expenses for 1978 and a projection of the remaining expenses during that year. For the fiscal cost center the 1978 CIP totaled $127,744. This base figure was then increased for "volume and intensity" by $4,160. Volume is an automatic allowance given for an increase in units of service measured by admissions. Intensity is a similar automatic allowance given for increased amount of work per patient.

Next an "economic factor" of 7.25 percent was applied to the sum of the foregoing figures. This economic factor is an industry-wide figure intended to compensate the Hospital for inflationary trends based on recognized standard measures such as the wage price index and the consumer price index. See, SHARE Manual, Section I. After
the preceding adjustments have been made, the resulting figure is known as the "calculated reasonable cost". In this cost center the calculated reasonable cost amounted to $141,467. Subtracting this calculated reasonable cost from the 1979 budgeted cost for this cost center in the amount of $206,927 yields $65,460 which represents the cost originally questioned as to reasonableness. Once the approximately $22,000 allowed by the analyst at the detailed review is added back, however, the cost questioned as to reasonableness is reduced to roughly $43,500.

Additionally, the Department conducted a peer group comparison which involved contrasting the Hospital's 1978 unit CIP for this cost center with similar unit costs expended by comparable hospitals. Those costs exceeding the median unit cost which other hospitals spend for the same cost center by a specified percentage ("challenge ratio") are presumed to be unreasonable. As shown on the median run made in 1978 the Hospital's unit cost for this cost center was $48.47 whereas the median unit cost of comparable hospitals was $60.89. Thus, the Hospital's 1978 unit cost was only 80 percent of the median unit cost of its peers. Since the challenge limit for this cost center was $66.97 (representing a challenge ration of 110 percent of the median), the unit cost for this particular cost center is within the challenge limit and hence must be presumed reasonable under the 1979 Guidelines. Taking into account the amounts allowed at the detailed review, the unit cost is increased by some $8.00 to approximately $56.50 which is still under the median and the challenge limit. If the Department were also to allow $27,000 per half year or an annualized amount of approximately $50,000 for a computer system, the unit cost would be raised again by about $14.00 per admission to $70.50 which would be over the challenge limit. One troublesome aspect of the proposal, Currie mentioned, was that the Hospital did not indicate any "trade-offs" or anticipated reductions in costs which would accrue from acquisition of the computer system.

In its documentation the Hospital identified the need to computerize the fiscal department as necessitated by the Standard Hospital Uniform Reporting ("SHUR") program which the federal government planned to implement by January 1, 1980. Currie indicated that SHUR was a reporting proposal by the Department of Health, Education and Welfare applicable to hospitals across the nation. Due to an increase in costs for smaller hospitals, Currie asserted, funding for this program was removed from the federal budget and implementation of SHUR has been delayed indefinitely. At the suggestion of the
Hospital Association, most New Jersey hospitals earmarked $50,000 in their 1979 budgets for SHUR costs. Given the fact that SHUR would be postponed or scrapped altogether, these requests were routinely denied by the Department.

On cross-examination Currie acknowledged that he lacked qualifications to evaluate whether the bookkeeping equipment currently used by the Hospital was adequate to meet its needs. He agreed that at the detailed review and in supplemental documentation the Hospital had expressed its request in terms of replacing obsolete and inadequate equipment and not merely for the purpose of compliance with anticipated SHUR requirements. Nonetheless, Currie insisted that the Hospital should have found a more economical alternative for updating its equipment such as purchasing less expensive bookkeeping machines.

McNamara, who is in direct charge of the fiscal department of the Hospital, was recalled to present its reasons for this request. Presently two phases of the Hospital's fiscal operations, i.e., payroll and accounts payable, are computerized by an outside service bureau and all remaining phases are handles manually. The only equipment used internally to keep accounts was described by McNamara as an outdated NCR 4200 bookkeeping machine consisting of a hotel-type posting mechanism. Although McNamara candidly admitted that the Hospital could survive using the existing system, he complained that the present arrangement left much to be desired from the standpoint of efficiency. Primarily the problem areas, as McNamara saw them, were patient billing and receivables. Under the current manual posting system, insufficient detail is provided for third party cost reporting and billing without going back to the original charging documents. Consequently, McNamara complained his shorthanded staff was endlessly involved in trying to get caught up on billing, especially during the summer vacation months. Collection of necessary information, including cross-reports required by Medicare, general ledgers, financial reports and aged trial balances, must all be compiled by hand. Much time and effort are expended merely getting the monthly reports out. An advantage of switching to a computer would be that the system would store such information in its memory and instantly generate a wide variety of useful statistical reports. For the past few years, the Hospital's independent auditors have been pushing for computerization of billing and accounts receivable procedures. Moreover, McNamara knew of at least two similar hospitals which make extensive use of computers: Millville Hospital which leases its equipment
from Shared Medical Services and Kessler Memorial Hospital which purchased its equipment from IBM. He emphasized that the Hospital's plan is to lease software under a shared program as opposed to the more costly and less flexible method of installing its own in-house system. In sum, McNamara urged that the computer system, while not absolutely essential to its ongoing operation, was intended to bring the Hospital's accounting procedures in accord with modern business techniques.

During cross-examination, McNamara conceded that the original budget submission gave implementation to SHUR as the sole reason for requesting this increase. When it became evident that SHUR wasn't going to be immediately adopted, however, the Hospital re-evaluated its request in light of other benefits which could be derived from computerization. Significantly, McNamara agreed that the SHUR program contemplated a very detailed and meticulous method of accounting. Therefore, the SHUR program necessitated a computer capable of much more sophisticated operations than the other tasks the Hospital wanted to accomplish. Even though the Hospital could get by with less than what SHUR required, the Hospital wanted the capacity to convert to the SHUR program in the even it became a reality.

Aside from a savings of approximately $8,000 resulting from termination of the outside contract to perform the Hospital's payroll and accounts payable operations, McNamara was unable to point to any tangible savings resulting from computerization. As of 1978, the Hospital employed 13 full time equivalent workers in its fiscal department. None of these positions would be eliminated if a computer system were adopted, although the Hospital would not have to hire additional personnel. Further hiring was not anticipated at this time anyway, due to the lack of physical space to put new employees. Improvement in cash-flow brought about by more prompt billing would not achieve any savings in interest on debt because the Hospital has been able to meet its expenses without borrowing money. Possibly there may be some reduction in overtime expenses, currently amounting to between $5,000 and $6,000 per year, but McNamara remained doubtful that overtime could ever be entirely eliminated.

After careful review of the documentary evidence and the testimony regarding this cost center, I FIND the following facts:

1. For fiscal, the 1978 CIP totaled $127,744. Following the SHARE methodology, this amount was increased for volume and intensity by $4,160 and an economic factor of 7.25 percent
was applied to the adjusted CIP resulting in a calculated reasonable cost of $141,467.

2. A 1979 budget submission by the Hospital proposed $206,927 for this cost center. Included within this request was $27,000 for a computer system covering the half year period beginning July 1, 1979.

3. The difference of $65,460 between the budgeted cost and the calculated reasonable cost was questioned as to reasonableness in accordance with the 1979 Guidelines. An additional allowance of approximately $22,000 reduced the cost questioned as to reasonableness to roughly $43,500.

4. Under a peer group comparison, the Hospital’s 1978 unit cost for this cost center was $48.47 while the median cost of comparable hospitals was $60.89. Thus, the Hospital’s unit cost was only 80 percent of the median. This percentage is well below the challenge ratio of 110 percent.

5. If, in addition to amounts previously allowed, the Department were to allow $27,000 per half year or approximately $50,000 per year for a computer system, the unit cost would be raised by $70.50 which exceeds the challenge limit.

6. Originally the documentation submitted by the Hospital described the need for a computer system exclusively in terms of implementing the SHUR program. Only as an afterthought did the Hospital add other purposes in support of its request.

7. Funding for the SHUR program was removed from the federal budget and implementation has been delayed indefinitely.

8. Although the defunct SHUR program contemplated more sophisticated accounting procedures than would otherwise be necessary, the Hospital failed to reduce the ambitious scope of its project.

9. A computer system is not absolutely essential for the ongoing operations of the Hospital. In this sense, the request is for a luxury rather than a necessity.

10. The record is devoid of any showing that the Hospital carefully shopped around and selected the most reasonably priced computer system suitable for its limited needs.

11. There has been an inadequate showing of cost-savings which ought to result from the use of a computer. Although the computer would do the job presently performed manually by personnel, no corresponding reduction in staff will be made. No savings will be achieved on interest paid on debt. Any reduction of overtime expenses is purely speculative.
Based upon the facts adduced at the hearing and the applicable law, I CONCLUDE that the Hospital has not sustained its burden of proving the reasonableness of its budget request in this cost center.

When evaluating any request for management changes, the proper approach is to measure the additional cost against the dollar value or other benefit derived from the expenditure. 1979 Guidelines (at page G-6). Ordinarily the Department looks more favorably at increases in cost centers at which the unit cost falls below the median. Even in such cases, the Department never automatically grants the request but requires the Hospital to justify the need for any extra dollars to be spent. By definition, the median is the mid-point between those numbers below and above it. If all expenses below the median were granted as a matter of course, the median would constantly be creeping upward as the prior median became the new starting point.

Last year the Hospital's unit cost in the fiscal cost center was below the median spent by comparable hospitals. Nonetheless, the Hospital has not sufficiently established the need for the extravagant computer system it has proposed. As discussed in the factual findings above, the computer system would be a mere convenience rather than a necessity. Once the SHUR program was pigeon-holed by the federal government, the primary justification for the request was no longer valid. The Hospital did not demonstrate that it carefully considered the alternatives with a view toward selecting the most economical system available for its particular purposes. Nor did it prove the cost-savings which would be reasonably anticipate- as a result of converting from a manual to a computerized fiscal department. In short, the Hospital's proposal was not shown to be cost efficient in accomplishing its specific objectives.

Moreover, if the amount allowed at the detailed review and the amount requested for the computer system are added, the resulting unit cost would exceed not only the median but the challenge limit as well. For this reason alone, the increase should not be granted unless the Hospital could show far more compelling reasons than were presented at the hearing.

Plant

Plant is defined as the cost center pertaining to "maintenance and operation of an institution's buildings and equipment in a state of readiness required to perform hospital, auxiliary and other operations of the institution" (SHARE Manual at B-66). In this cost center, the
Hospital is seeking legal and management changes involving an explanation of its contract for preventive maintenance of its biomedical and electrical services costing $9,000.

On behalf of the Department, Currie explained its reasons for disallowing the Hospital’s request. Currie testified that the 1978 CIP for the plant cost center totaled $131,243. Applying the economic factor of 7.25 percent to this figure, the result is a calculated reasonable cost amounting to $140,758. Subtracting this calculated reasonable cost from the 1979 budgeted cost of $156,593 yields $15,835 which represents the cost questioned as to reasonableness.

Additionally, the Department conducted a peer group comparison which involved contrasting the Hospital’s 1978 CIP for this cost center with similar unit costs expended by comparable hospitals. As shown on the computer print-out marked into evidence in 1978 the Hospital’s unit cost for this cost center was $2.12 whereas the median unit cost of comparable hospitals was only $1.90. Thus, the Hospital’s 1978 unit cost was 112 percent of the 1978 median cost of its peers. Since the challenge limit for his cost center was $2.08 (representing a challenge ratio of 110 percent of the median), the unit cost for this particular cost center was above the challenge limit and hence presumed to be unreasonable under the 1979 Guidelines.

Although the new contract did contain some increased services, Currie felt that it was basically the same contract as last year. Going from a cost of about $5,000 in 1978 to about $15,000 in 1979, the price for this contract rose 200 percent in a single year. Given the fact that this cost center was already too high, Currie contended that an additional increase of such magnitude should not be granted at this time.

As its last witness, the Hospital recalled Wisda who had negotiated the 1979 renewal of the contract with Honeywell, Inc. Its purpose, Wisda indicated, was to provide preventive maintenance on all biomedical and electrical equipment in order to insure safe operation and compliance with the requirements of the Joint Commission on Accreditation of Hospitals (“JCAH”). These requirements, which include testing and verification of performance of all electronic patient care equipment at intervals not exceeding six months and the maintenance of written records of inspection, are set forth in the Hospital’s Appeal Document. While the JCAH never actually cited the Hospital for any deficiencies, in January 1978 it informed the Hospital that there standards were applicable to a satisfactory preventive maintenance program.
Major changes in the new Honeywell contract are documented in the Hospital's supplementary material marked into evidence. Among the new features are the preparation of written reports to comply with JCAH record-keeping requirements, technical advisory services providing information on the reliability of equipment, inservice training of staff on the proper use of equipment and incoming inspection of all equipment before it goes into use. In 1978 the contract covered 63 items of equipment and 63 outlets. In 1979 the contract was expanded to cover 125 items of equipment and 384 outlets. Prior to accepting Honeywell's offer, Wisda had obtained a lower quotation from BEST Services Corporation. The decision to stay with Honeywell was based on satisfaction with Honeywell's past services and the greater comprehensiveness of Honeywell's program.

On cross-examination, Wisda attributed the high cost in this cost center to two factors. First, the Hospital has a very complete in-house maintenance program for doing its own electrical, plumbing and carpentry work. Second, the unit cost is measured by square footage putting the Hospital at a disadvantage because of its small physical size. On account of the substantial investment required for monitoring, Wisda did not think the Hospital could perform its own inspection of its biomedical and electrical equipment. In one respect the new contract is less favorable than the old contract. Previously any repair parts costing more than $15.00 were extra, but in the new contract all repair parts are extra. Finally, Wisda conceded that the JCAH standards apply uniformly to all hospitals in its peer group and not just to this hospital.

After careful review of the documentary evidence and the testimony regarding this cost center, I FIND the following facts:

1. For plant, the 1978 CIP totaled $131,243. Following the SHARE methodology, an economic factor of 7.25% was applied to the foregoing figure resulting in a calculated reasonable cost of $140,758.

2. A 1979 budget submission by the Hospital proposed $156,593 for this cost center. Included within this request was $9,000 for an expansion of the Hospital's contract for preventive maintenance of its biomedical and electrical services.

3. The difference of $15,835 between the budgeted cost and the calculated reasonable cost was questioned as to reasonableness in accordance with the 1979 Guidelines.

4. Under a peer group comparison, the Hospital's 1978 unit cost for this cost center was $2.12 while the median cost of com-
parable hospitals was only $1.90. Thus, the Hospital's unit cost was 112 percent of the median. This percentage is above the challenge ratio of 110 percent.

5. Essentially the 1979 Honeywell contract serves the same purpose as the 1978 Honeywell contract which is to provide preventive maintenance for the Hospital's biomedical and electrical equipment. However, the new contract contains several features not included in the old contract. It also covers 62 more items of equipment and 321 more outlets.

6. Between 1978 and 1979, the price for this contract rose approximately 200 percent.

7. All hospitals in this Hospital's peer group are subject to the same preventive maintenance requirements and a majority are able to meet their responsibilities in this area on a lower budget.

Based on the facts adduced at the hearing and the applicable law, I CONCLUDE that the Hospital has not sustained its burden of proving the reasonableness of its budget request.

Notwithstanding the already high cost, the Hospital renewed its preventive maintenance contract at a price increase of approximately 200 percent. Other hospitals subject to the same preventive maintenance requirements are able to satisfy these standards without spending as much money. See, The Medical Center at Princeton, N.J. v. Finley, (N.J. App. Div., A-4249-77, May 22, 1979) (unreported); In re 1976 Hosp. Reimbursement Rate for St. Mary's Hosp., (N.J. App. Div., A-1613-76, February 24, 1979) (unreported). It has been noted that, "When cost-of-complicance is tendered in a rate review proceeding to justify a budget increase, the agency is entitled to demand substantial or persuasive proof from the hospital that these costs in fact are compelled and constitute the necessary, unavoidable and irreducible cost of compliance." In re 1976 Hosp. Reimbursement Rate for Kessler Mem. Hosp., supra, at 584 (concurring opinion). Viewed as a question of allocation of limited resources, the Hospital has not adequately explained why it too cannot perform the service with the funds already allocated to this cost center.

Emergency Services (Physicians)

As a result of application of the duplication factor, the issue raised by the Hospital in this cost center has become moot. Accordingly, the Hospital agreed to withdraw its appeal with respect to this cost center subject to the following stipulation:
If the appeals by the Hospital for the years 1976 through 1978 result in a greater approved cost so that the minimum base period challenge for 1979, then the Department of Health will allow the Hospital to reopen the hearing for 1979 in order to present additional testimony regarding the emergency services (physicians) cost center.

Nancy Seline, Rate Analyst for the Department of Health, represented on the record that she had authority to make this binding stipulation on behalf of the Department.

For the foregoing reasons, it is ORDERED that:
(a) In the policy fringe benefits cost center, the Hospital's request for the upgrading of its employee hospitalization and medical insurance program costing $65,000 is DENIED.
(b) In the fiscal cost center, the Hospital's request for a computer system costing $27,000 is DENIED.
(c) In the plant cost center, the Hospital's request for an expansion of its preventive maintenance contract costing $9,000 is DENIED.
(d) In the emergency services (physicians) cost center, the Hospital has withdrawn its appeal subject to the stipulation recited earlier in this decision.

ADOPTED BY SILENCE PURSUANT TO N.J.S.A. 52:14B-10(c) BY THE DEPARTMENT OF HEALTH.