# PROVIDER REIMBURSEMENT REVIEW BOARD
# HEARING DECISION

ON THE RECORD
2002-D36

**PROVIDER** –
Home Comp Care, Inc.
Matteson, Illinois

Provider No. 14-7525

**vs.**

**INTERMEDIARY –**
Blue Cross and Blue Shield Association/
Palmetto Government Benefits
Administration

**DATE OF HEARING-**
July 18, 2002

Cost Reporting Periods Ended
April 30, 1995

**CASE NO.** 97-1761

**INDEX**

ISSUES:

1. Were the Intermediary's adjustments to disallow patient advocate/community relations costs proper?

2. Was the Intermediary's elimination of accrued expenses proper?

3. Was the Intermediary's disallowance of pension costs proper?

4. Was the Intermediary's treatment of executive compensation reasonable?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Home Comp Care, Inc. ("Provider") was a home health agency certified by the Medicare Program on November 11, 1992, located in Matteson, Illinois.

HCC's cost report was audited by Blue Cross and Blue Shield of Illinois, now represented by Palmetto Government Benefits Administration ("Intermediary"). On September 4, 1996, the Intermediary issued a Notice of Program Reimbursement ("NPR") based on its review of the Provider's April 30, 1995 cost report. On March 4, 1997, the Provider appealed the Intermediary's adjustments to the Provider Reimbursement Review Board ("Board") and has met the jurisdictional requirements of 42 C.F.R. §§ 405.1835-.1841.[1] The application of the Intermediary's adjustments in question reduced Medicare reimbursement by approximately $361,401.

The Provider was represented by James M. Ellis, Esquire, of Holleb & Coff. The Intermediary's representative was James Grimes, Esquire, of the Blue Cross and Blue Shield Association.

Issue No. 1 – Patient Advocate/Community Relations Costs

FACTS:

In the previous year's audit fiscal year ended ("FYE") (04/30/94), the Intermediary examined the Provider's job duties and time study for Patient Advocator. Based on that review, the Intermediary determined that 43.22% of the duties performed by this individual were for non-reimbursable promotional activities.[2] The Intermediary applied the same results (43.22%) to the current fiscal year under appeal (04/30/95). Therefore, the Intermediary reclassified $38,108 of the Patient Advocator salaries and benefits from the administrative and general ("A & G") cost center to a non-reimbursable cost center through audit adjustment number 4.[3] In addition, for the current fiscal year under question, the Provider created a new position entitled, Director of Community Relations.

[1] See Intermediary's final position paper at 2.
[2] See Intermediary's final position paper at 3 and Exhibit I-6, workpaper 2-8A-2.
[3] See Intermediary's final position paper Exhibit I-6, workpaper 4-4, 2 of 2.

The Intermediary reviewed the submitted job description and interviewed the employee responsible for performing community relations activities. Based on the Intermediary's interview and analysis of the job description, it concluded that the duties of the Director of Community Relations included educational/community awareness functions to the public and representing the agency at health fairs. Thus, the Intermediary reclassified 100% ($23,413) of the Director of Community Relations salary and benefits from the A & G cost center to a non-reimbursable cost center through audit adjustment number 5.[4]

PROVIDER'S CONTENTIONS:

The Provider contends they attempted to increase the community's awareness that home health care services were available to low income individuals. The Agency employed several "patient advocates" and "community relations" individuals whose jobs were to act as liaisons between current patients and health care professionals, contact health care professionals regarding home health services, increase the community's awareness of home health care, and increase the Provider's public image.[5]

The Provider asserts that the Intermediary disallowed the claimed costs for these activities based on its belief that the intent of the Provider was to increase the patient utilization/visits, which the Intermediary viewed as a non-allowable function.[6]

The Provider alleges that the Intermediary did not review the employees' job descriptions before the disallowance was made. Instead, the Intermediary determined that the employees' salaries were not allowable based on job titles and the prior years' audit finding. The Provider cites Girling Health Care, Inc. v. Blue Cross and Blue Shield Association/Blue Cross and Blue Shield of Iowa,[7] PRRB Dec. No. 97-D96 September 10, 1997 declined rev. HCFA Admin November 7, 1997 Medicaid and Medicare Guide (CCH) ¶ 45,696. In this case, the Board found that the Intermediary's audit was not expansive enough to support the 100% reclassification of costs, since the Intermediary combined cost year audits and did not audit each year on its own.

The Provider insists that the Intermediary's adjustment to the community awareness costs was arbitrary, capricious and contrary to law, since there is nothing in the Medicare regulations which limits the allocability of the authorized advertising, liaison or education because of a job title or alleged intent. The Provider emphasizes HCFA Pub. 15-1 §§ 2113.1, 2113.4 and 2136.1. HCFA Pub. 15-1 § 2113.1 provides that "[t]he cost of coordination activities, which ease the patient's transition from hospital or SNF to the home under the care of an HHA, are allowable." Once the patient's physician determines that the patient requires home care and the patient chooses the home health agency to perform the services, allowable coordination activities may occur.[8] Examples of allowable coordination activities are listed in HCFA Pub. 15-1 § 2113.1 as follows:

---

[4] See Intermediary's final position paper Exhibit I-6, workaper 4-4, 2 of 2.
[5] See Provider's final position paper at 6.
[6] See Provider's final position paper at 7.
[7] Id.
[8] See Provider's final position paper at 9.

> A. Explaining the agency's policies to patients and responsible family members following referral.
>
> B. Assisting in establishing a definitive home care plan prior to discharge, including assessment of the appropriateness of the requested services, medical supplies and appliances.
>
> C. Assuring the HHA is ready to meet the patient's needs at the time of discharge. This entails making arrangements for any special medical supplies or appliances, making arrangements for training agency personnel regarding unfamiliar procedures or problems pertaining to the patient's care, and communicating information regarding the patient to agency personnel.

The Provider claims that, as discussed in HCFA Pub. 15-1 §§ 2113.4 and 2136.1, the cost of (1) advertisement, (2) patient coordination and (3) education and liaison activities with other members of the health care community are allowable under the applicable Medicare laws, regulations, and instructions.[9] With respect to some of these activities, the Provider states that the Intermediary previously admitted that the costs were allowable. On the 04/30/94 cost report the Provider contends that the Intermediary allowed 43% of the costs associated with the patient advocate and community relations employees. Nonetheless, the Provider asserts that the Intermediary has disallowed 100% of the costs of the employees that performed these activities and reclassified those costs to a non-reimbursable cost center.[10]

The Provider does not believe that the Intermediary has provided any explanations for its adjustment and total disallowance. The Provider contends that the advertisement, educational, liaison and coordination functions are necessary and proper and should be fully reasonable under § 1814(b) of the Social Security Act ) (the "Act") (42 U.S.C. § 1395f(b)), as providers of health care services to Medicare beneficiaries are entitled to be reimbursed for the "reasonable costs" of providing such services. Section 1861(v) of the Act (42 U.S.C. § 1395x(v)) provides that the reasonable costs of services shall be costs actually incurred, excluding any part of the incurred costs found to be unnecessary in the efficient delivery of health services, and shall be determined in accordance with the regulations.[11]

The Provider also cites 42 C.F.R. § 413.9(b)(2) and HCFA Pub. 15-1 § 2102.1, which define necessary and proper costs, as costs that are appropriate and helpful in developing and maintaining the operation of patient care facilities. These costs are usually common and accepted occurrences in the field of the Provider's activity.

---

[9] See Provider's final position paper at 7.
[10] Id.
[11] See Provider's final position paper at 8.

In conclusion, the Provider maintains that the Medicare Conditions of Participation for home health agencies also require home health coordination activities. 42 C.F.R. §§ 484.10(c) and 484.14(g). Accordingly, under the applicable laws, regulations and instructions, the cost of advertising, patient coordination, education and liaison activities are allowable. [12]

INTERMEDIARY'S CONTENTIONS:

The Intermediary claims that their audit determination for Patient Advocator was based on the submitted job description. The Intermediary insists that, with the aid of the Provider, they both determined that 43.22% of the activities for the patient advocator were non-reimbursable.[13]

The Intermediary contends that, unlike the previous year audit, there were two employees performing the duties of patient advocator in the current year versus one employee in the prior year. The Intermediary asserts that they interviewed the applicable personnel and confirmed whether similar functions applied and whether the allocation of time was reasonable.

The Intermediary recognized that a new position in regard to community relations was created in the year in question. Based on the Intermediary's interview and review of the job description, the community relation's position entailed educational/community awareness to people other than patients of the agency. The Intermediary insists that the Provider did not keep any records of the specific activities performed by the community relation's employee. Therefore, the Intermediary reclassified the community relations costs to a non-reimbursable cost center.

The Intermediary would like it to go on record indicating that the original adjustment proposed to community relations and patient advocator costs was to disallow 100% of these costs. However, after reviewing the applicable job descriptions and interviewing the necessary employees who perform these tasks, a mutual agreement was reached. The Intermediary suggested that by tracking the specific functions/duties, the percentage of the reclassification could be amended in the subsequent periods.[14]

Issue No. 2 – Accrued Expenses

FACTS:

The Intermediary disallowed accrued salaries ($43,657), accrued vacation ($15,330), accrued employee benefits ($3,340), Social Security taxes ($20,659) and FUTA taxes ($16,062) based on its review of the Provider's records. The Intermediary compared the

[12] See Provider's final position paper at 10.
[13] See Intermediary's final position paper at 3.
[14] Id.

as-filed salaries claimed on the cost report to the actual salaries paid and eliminated the difference through audit adjustment numbers 9, 10 and 11.[15]

During the review, the Intermediary determined that the applicable accruals at the end of the year (12/31/94) for tax purposes were not reversed for proper accounting purposes and that the Provider is not appropriately accounting for vacation expense.[16]

In examining the Provider's records the Intermediary concluded that the Provider reported accrued vacation and accrued salary in the payroll general ledger account and also in the Social Security taxes general ledger account (audit adjustment number 28).[17] In addition, the Provider did not submit any documentation to the Intermediary to ensure proper liquidation of FUTA tax for the year ended December 31, 1994 (audit adjustment number 29).[18]

PROVIDER'S CONTENTIONS:

The Provider contends that the Intermediary did not provide any rationale for its adjustments disallowing accrued expenses for salaries, benefits, vacation pay, Social Security and FUTA taxes.

The Provider asserts that the Medicare statute states that providers of services are entitled to payment of the "reasonable cost" incurred in providing health services to Medicare beneficiaries pursuant to 42 U.S.C. §1395x(v)(1)(A). The Provider insists the Secretary has defined reasonable costs to include those costs which are necessary and proper in rendering health services, and further defines "necessary and proper" as those costs which are "appropriate and helpful" in developing and maintaining the operation of patient care facilities and activities. 42 C.F.R. § 413.9(b)(2).[19]

The Provider cites 42 C.F.R. § 413.9, which states in part:

> [r]easonable cost includes all necessary and proper expenses incurred in furnishing services . . . . It includes both direct and indirect costs and normal standby costs.
>
> Necessary and proper costs are costs that are appropriate and helpful in developing and maintaining the operation of patient care facilities and activities. They are usually costs that are common and accepted occurrences in the field of the provider's activities.

The Provider contends employee salaries, benefits and vacation pay are allowable costs under Medicare. 42 C.F.R. § 413.5 and HCFA Pub. 15-1 §§ 2144 and 2146. The

---

[15] See Intermediary's final position paper Exhibit I-5, pages 8, 9, 10, 27 and 28.
[16] See Intermediary's final position paper Exhibit I-6, workpaper 4-4, 2 of 2.
[17] See Intermediary's final position paper Exhibit I-6, workpapers, 6A, 6B and 6C.
[18] See Intermediary's final position paper Exhibit I-6, workpaper 6.
[19] See Provider's final position paper at 11.

Provider asserts that 42 C.F.R. § 413.24 requires that accruals of allowable costs be recognized as an allowable cost when an obligation to pay the liability exists and the amount of the liability is readily determinable.

The Provider also contends that according to Financial Accounting Standards Board ("FASB") statement No. 43, accruing liability for salaries, benefits, and vacation pay is a widely accepted reporting practice in the health care industry. Accordingly, the Provider believes that it properly claimed the accrued salary, benefits and vacation expense, along with Social Security and FUTA taxes associated with those expenses.[20]

It is the Providers belief that since the Intermediary has not offered any support for its adjustments, and the claimed costs are allowable the adjustments should be reversed.

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends the adjustments are the result of reversing entries not being set-up in the subsequent period for a prior period accrual involving audit adjustments 9, 10 and 11. Intermediary audit adjustment number 28 resulted from the recording of accrued salary/vacation expense twice, once in the salary accounts and again in the Social Security tax accounts. Adjustment number 29 was the result of FUTA expense for 12/31/94 not being liquidated.[21]

The Intermediary asserts the issue at hand is not one of whether the expenses identified are allowable, but whether the costs are accounted for properly to obtain reimbursement. Therefore, the Intermediary requests that the Board affirm its determination.

Issue No. 3 – Pension Expense

FACTS:

The Provider started a new pension plan for its employees effective January 1, 1995. In reviewing the pension plan, the Intermediary determined that the pension expense was not liquidated within one year's timeframe. Therefore, the Intermediary disallowed the pension expense of $89,349 for improper liquidation of liability.[22]

The Intermediary indicated that their audit adjustment was proposed because the Provider failed to 1) show that the pension was a qualified plan under Internal Revenue Service ("IRS") regulations, 2) supply the Intermediary with an actuarial report to determine the liability/funding amount, and 3) document that the expense claimed was actually funded within the specified timeframes.[23]

PROVIDER'S CONTENTIONS:

[20] See Provider's final position paper at 12.
[21] See Intermediary's final position paper at 4.
[22] See Intermediary's final position paper Exhibit I-6, workpaper 6-1.
[23] See Intermediary's final position paper at 5.

The Provider contends the Intermediary disallowed the pension plan expense, claiming that there was insufficient documentation to support the amounts claimed on the cost report. The Provider asserts that the Intermediary's claim is misplaced and cites 42 C.F.R. § 413.20,[24] which provides in part:

> Financial Data and Reports
>
> (a) General. The principles of cost reimbursement will require that providers maintain sufficient financial records and statistical data for proper determination of costs payable under the program. Standardized definitions, accounting, statistics, and reporting practices which are widely accepted in the hospitals and related fields are followed. Changes in these practices and systems will not be required in order to determine costs payable under the principles of reimbursement. Essentially, the methods of determining costs payable under Medicare involve making use of data available from the institution's basic accounts, usually maintained, to arrive at equitable and proper payment for services to beneficiaries.
>
> . . .
>
> (d) Continuing provider recordkeeping requirements.
>
> (2) The provider must permit the intermediary to examine such records and documents as are necessary to ascertain information pertinent to the determination of the proper amount of program payments due.

42 C.F.R. § 413.24[25] provides in relevant part as follows:

> Adequate Cost Data and Cost Finding
>
> (a) Principle. Providers receiving payment on the basis of reimbursable costs must provide adequate cost data. This must be based on their financial and statistical records which must be capable of verification by qualified auditors. The cost data must be based on an approved method of cost finding and on the accrual basis of accounting.
>
> . . .
>
> (b) Definitions – (1) Cost Finding. Cost finding is the process of recasting the data derived from the accounts ordinarily kept by a provider to ascertain costs of the various types of services rendered. It is the determination of these costs by the allocating of direct costs and proration of indirect costs.

[24] See Provider's final position paper at 12.
[25] See Provider's final position paper at 13.

. . .

(c) Adequacy of cost information. Adequate cost information must be obtained from the provider's records to support payments made for services rendered to beneficiaries. The requirement of adequacy of data implies that the data be accurate and in sufficient detail to accomplish the purposes for which it is intended. Adequate data capable of being audited is consistent with good business concepts and effective and efficient management of any organization, whether it is operated for profit or on a nonprofit basis.

Thus, the Provider insists that by law, the Intermediary cannot require documentation beyond an institution's basic accounts as usually maintained, consistent with good business concepts and effective and efficient management of any organization. The Provider believes that they have presented the Intermediary with sufficient documentation to support the claimed pension plan costs. That documentation includes 1) a November 27, 1992, IRS approval letter that deemed the Provider's pension plan a "qualified plan" under the IRS code; 2) bank account statements establishing that the pension plan funds were deposited in the pension account; and 3) General Ledger and financial accounts evidencing the claimed pension plan costs.

The Provider asserts that the Intermediary has failed to support its adjustment or provide any rationale for its determination to disallow pension plan costs based on inadequate information.

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that the Provider has not submitted an approval letter from the IRS indicating that the pension plan is a "qualified plan." The Intermediary asserts that bank statement deposits and general/financial records document what has been deposited and claimed; however, these documents do not provide evidence as to what the established liability/funding amount was to be determined by an actuary.

The Intermediary cites HCFA Pub. 15-1 § 2142.3 as an instructional reference, which states that:

> "[i]n order for a plan to be considered funded for purposes of Medicare cost reimbursement, the liability to be funded must have been determined and the provider must be obligated to make payments into the fund. Funds existing at the discretion of the provider are not considered valid, and such plans are treated as direct pension plans. Payments are allowed only when paid to the beneficiary.

In conclusion, the Intermediary requests the Board to affirm its determination.

Issue No. 4 – Executive Compensation

FACTS:

The Intermediary reviewed the compensation of the agency's key employees. As part of their audit process the Intermediary performed a comparison of the agency's executive compensation to the Dunham Compensation Study. In doing so, the Intermediary determined that management employees of the agency exceeded the Dunham Study compensation guidelines. Therefore, the Intermediary proposed to disallow $111,487 for compensation and $3,735 for FICA taxes collectively, for the following executives:[26]

1) Anthony Alexander – Administrator ($63,990)
2) Suetler Swan – Chief Operating Officer ($2,335)
3) Joseph Kenny – Controller ($2,226)
4) Erland Fojelin – Associate Controller ($11,954)
5) Sheila Swan – Office Manager ($8,894)
6) Marcia Cutright – Director of Nursing/Supervisor ($14,930)
7) Juanita Taylor – Director of Therapy Services ($3,763)

The Provider claimed on its as-filed cost report $150,000 in total compensation for Anthony Alexander; however, the Intermediary determined that only $90,481 was liquidated within 75 days after the current fiscal year end. Therefore, the Intermediary noted during the audit that had they not subjected the administrator's wages to the Dunham Study, they would have disallowed the excess amount since it was not liquidated within a timely manner.

PROVIDER'S CONTENTIONS:

The Provider contends that the Intermediary disallowed portions of key employee and owner's compensation based on a 1978 Dunham Compensation Study. It is the Provider's position that the Intermediary's contentions are erroneous due to improper application of the Dunham Study. The Provider asserts the Dunham Study is outdated and does not compare the Provider's executives' compensation with executive compensation at similar facilities as required by Medicare regulations.[27]

The Provider references HCFA Pub. 15-1 § 904, which states that:[28]

> [i]n general, the determination as to the reasonableness of a person's compensation is made by comparing it with the compensation paid to other individuals in similar circumstances. To obtain uniformity in the application of the principle, the Intermediary (1) identifies compensation paid to individuals other than owners by comparable institutions in the same geographical area, (2) furnishes this data to the [HCFA] regional office where it is consolidated with data obtained by other intermediaries to produce ranges of reasonable compensation to be used in the same area,

[26] See Intermediary's final position paper Exhibit I-6, workpaper 26, page 2 of 2.
[27] See Provider's final position paper at 14.
[28] See Provider's final position paper at 15.

> and (3) applies a set of criteria based on the qualifications and responsibilities of the owner to determine his placement within the range.

The Provider argues Medicare regulations and instructions require the Intermediary to conduct surveys of providers, group the resulting data by type of provider, and submit such data to HCFA's regional offices for consolidation into ranges. There is no alternative methodology provided for in the general instructions governing owner's compensation.

The Provider asserts that the general instructions are quite clear on this point. They state that:

> [i]ntermediaries have the responsibility for evaluating the reasonableness of an owner's compensation . . . On the basis of information obtained by surveys of providers, ranges of compensation for comparable institutions will be established. Intermediaries will utilize these ranges both for final settlement and when setting interim rates.

HCFA Pub. 15-1 § 905.1. [29]

The Provider claims that despite these general instructions no national surveys have been conducted and no ranges have been published by HCFA in accordance with this methodology since 1974.

The Provider insists the Intermediary's application of the 1978 Dunham Study to the Owner's compensation in this case is not accurate. The salary ranges developed by Dr. Dunham and illustrated in the 1978 Dunham Study are not representative of "total compensation ranges" for these executives. Rather the salary ranges set forth in the 1978 Dunham Study are only indicative of the base salary paid to executives in the hospital industry that participated in the survey. At the time the Dunham Study was created, Dr. Dunham testified that survey information established that benefits for these positions were in excess of 30% of salary.

The Provider cites Northside Home Health Care, Inc. v. Health Care Service, Corp./Blue Cross Blue Shield Association, PRRB Dec. No. 79-D97, April 1, 1993, Medicare and Medicaid Guide (CCH) ¶ 41,399, declined rev. HCFA Admin., May 21, 1993.[30] The typical benefits in this case included social security, pension, insurance and other expenses that the organization incurred on behalf of the employee. The Provider claims that other Intermediaries recognize that the Dunham survey does not include such benefits as deferred compensation or health insurance coverage. Specifically, in Harriet Holmes Health Care Services, Inc. v. Blue Cross and Blue Shield Association of Iowa, PRRB Dec. No. 88-D17, March 1, 1988, Medicare and Medicaid Guide (CCH) ¶ 37,026, declined rev. HCFA Admin., April 1, 1988 ("Harriet Holmes"),[31] Blue Cross and Blue

[29] See Provider's final position paper at 16.
[30] See Provider final position paper at 18.
[31] See Provider's final position paper at 19.

Shield of Iowa submitted a supplemental position paper wherein it argued that the Provider's total compensation, exclusive of deferred compensation and disability insurance coverage, should be compared with the 1978 Dunham Study.

The Provider indicated that the Intermediary updated the owner salary ranges by a cost of living increase factor communicated to Commerce Clearing House (CCH) and published in Medicare and Medicaid Guide (CCH) ¶ 5,623. However, the Provider insists that Intermediary failed to apply the Dunham Study properly by excluding a 30% increase to account for employee benefits, based on the Dunham Study's results.

The Provider notes that Dr. Dunham has testified indicating that the application of an update factor is not an appropriate method for updating the compensation survey in the long term. Rather, an update factor is only valid in the short term until new survey data is compiled.

The Provider contends that the Intermediary did not have the authority to unilaterally create limits under Medicare rules or policy. The functions of rule making and policy making are vested in the Secretary alone. As one court ruled:[32]

> "[t]he Fiscal Intermediary Blue Cross is only a hired hand, an independent contractor selected by the government to conduct audits. Blue Cross cannot speak with finality for the Secretary on the interpretation of regulations and certainly cannot make policy pronouncements.

Monongahela Valley Hospital, Inc. v. Bowen, 728 F. Supp. 1172, 1175 (W.D. Pa. January 16, 1990).[33]

Thus, the Medicare Act precludes Blue Cross from acting in the absence of, or contrary to, direction from the Secretary or HCFA or one of its regional offices.

The provider maintains that the Intermediary determination was not in accordance with 42 C.F.R. § 413.102,[34] which states:

> [r]easonableness of compensation may be determined by reference to, or in comparison with, compensation paid for comparable services and responsibilities in comparable institutions; or it may be determined by other appropriate means.

The Provider contends that the Intermediary's methodology of determining reasonable compensation was in violation of Medicare regulations and laws. The Intermediary has failed to prove that the Provider's reported compensation is substantially out of line in comparison to others in the same industry.

---

[32] See Provider's final position paper at 20.
[33] Id.
[34] Id.

The Provider asserts that Medicare regulations require the Intermediary to reimburse providers for their actual, reasonable costs in providing services to Medicare beneficiaries under 42 C.F.R. § 413.9.

The Provider argues that the Board has consistently placed the burden on intermediaries to determine that claimed compensation costs are substantially out of line with comparable Provider's. For example, in Alexander's Home Health Agency v. Blue Cross and Blue Shield Association/Blue Cross and Blue Shield of Mississippi, Inc., PRRB Dec. No. 88-D30,[35] September 2, 1988, aff'd, HCFA Admin., November 1, 1988, Medicare and Medicaid Guide (CCH) ¶ 37,439, the Board unanimously held that the Intermediary did not demonstrate that the Provider's costs were substantially out of line.

The Provider also cites Holy Cross Hospital v. Blue Cross and Blue Shield Association of New Mexico, PRRB Dec No. 92-D14, February 14, 1992, Medicare and Medicaid Guide (CCH) ¶ 40,066, aff'd, HCFA Admin April 13, 1992, Medicare and Medicaid Guide (CCH) ¶ 40,421 and Memorial Hospital/Adair County Health Center, Inc., v. Heckler, 829 F. 2d. 111 (D.C. Cir. September 18, 1987).[36]

The Provider contends that the Intermediary failed to establish that the Provider's claimed compensation was substantially out of line with comparable home health agencies. The Provider goes on to attest that the methodology used by the Intermediary was statistically invalid, as it failed to comport with Medicare regulations governing reasonable costs. Additionally, the Intermediary's chosen treatment of compensation costs did not take into consideration the size, scope of services, utilization, and other relative factors as required by 42 C.F.R. § 413.9.[37]

Finally, the Provider argues that the Intermediary has failed to support its adjustment to owner's compensation for the said fiscal year. The compensation claimed by the Provider is reasonable when compared to compensation paid for similar services by comparable agencies, and such amounts are clearly not "substantially out of line" with the compensation levels available in the relevant market. Therefore, the Intermediary's proposed adjustments cannot be upheld under the Medicare Act and regulations.

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that their disallowance of approximately $60,000 of the administrator's compensation was due to the Provider's failure to liquidate the promissory note (negotiable instrument) within a reasonable amount of time.

When reviewing key employees compensation the Intermediary performs a number of audit steps, 1) identify key personnel and their total compensation package, 2) reconcile compensation from the provider's records to the as-filed cost report, 3) perform a reasonableness test, 4) ensure that the amounts in question have been liquidated. Once

[35] See Provider's final position paper at 22.
[36] Id.
[37] See Provider's Final position paper at 21.

the Intermediary realized that the owner's compensation had not been liquidated it ceased to continue on with its reasonableness test, as it did not seem warranted, since the Provider had not paid the liability in question.[38]

The Intermediary states that it has been HCFA's long standing policy not to recognize, for the purpose of program payment, a Provider's claim for costs when it has not actually expended funds during the during the current cost reporting period. The regulation at 42 C.F.R. § 413.24(b)(2)[39] provides that under the accrual basis of accounting, revenue is reported in the period in which it is earned, regardless of when it is collected, and expenses are reported in the period in which they are incurred, regardless of when they are paid. Under that definition Provider's have claimed costs without evidence of having incurred actual expenditures or the assurance that liabilities associated with accrued costs will ever be fully liquidated through an actual expenditure of funds. To the extent that challenges to this policy were successful, the Program would be forced to pay for accrued liabilities that either may not be liquidated timely or may never be liquidated.

In closing, the Intermediary emphasizes that the Provider has not properly addressed the issue at hand, while contending that the Intermediary's determination was made based on reasonableness, instead of the timeliness of the liquidation of liabilities. The Intermediary contends that even at the date of the position paper the debt in question still has not been liquidated.

CITATION OF LAW, REGULATIONS AND PROGRAM INSTRUCTIONS:

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

| | | |
|---|---|---|
| § 1395x(v)(1)(A) | - | Reasonable Cost |
| § 1395f(b) | - | Amount Paid to Provider of Services |

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

| | | |
|---|---|---|
| §§ 405.1835-.1841 | - | Board Jurisdiction |
| § 413.5 | - | Cost Reimbursement: General |
| § 413.9 et seq. | - | Reasonable Cost/Cost Related to Patient Care |
| § 413.20 | - | Financial Data and Reports |

[38] See Intermediary's position paper at 6.
[39] Id.

| | | |
|---|---|---|
| § 413.24 et seq. | - | Adequate Cost Data and Cost Finding |
| § 413.102 | - | Compensation of Owners |
| § 484.10(c) | - | Conditions of Participation: Patients rights |
| §484.14(g) | - | Conditions of Participation: Organization Services, and Administration |

3. Program Instructions - Provider Reimbursement Manual (HCFA Pub. 15-1):

| | | |
|---|---|---|
| § 900 et seq. | - | Compensation of Owners |
| § 904 et seq. | - | Criteria for Determining Reasonable Compensation |
| § 905.1 | - | Procedures for Determining Reasonable Compensation-General |
| § 2102.1 | - | Reasonable Costs |
| § 2113.1 | - | Home Health Coordination Activities |
| § 2113.4 | - | Education and Liaison costs |
| § 2136.1 | - | Allowable Advertising costs |
| § 2142.3 | - | The Pension Fund |
| § 2144 | - | Fringe Benefits |
| § 2146 | - | Vacation Costs |

4. Case Law:

Girling Health Care, Inc. v. Blue Cross and Blue Shield Association/Blue Cross and Blue Shield of Iowa. PRRB Hearing Decision No. 97-D96, September 10, 1997, Medicare and Medicaid Guide (CCH) ¶ 45,646, declined rev. HCFA Admin., November 9, 1997.

Northside Home Health Care, Inc. v. Health Care Service, Corp./Blue Cross and Blue Shield Association, PRRB Dec. No. 79-D97, April 1, 1993, Medicare and Medicaid Guide (CCH) ¶ 41,399, declined rev. HCFA Admin., May 21, 1993.

Harriet Holmes Health Care Services, Inc. v. Blue Cross and Blue Shield Association of Iowa, PRRB Dec. No. 88-D17, March 1, 1988, Medicare and Medicaid Guide (CCH) ¶ 37,026, declined rev. HCFA Admin., April 1, 1988.

Alexander's Home Health Agency v. Blue Cross and Blue Shield Association/Blue Cross and Blue Shield of Mississippi, Inc., PRRB Dec. No. 88-D30, September 2, 1988, aff'd, HCFA Administrator, November 1, 1988, Medicare and Medicaid Guide (CCH) ¶ 37,439.

Monongahela Valley Hospital, Inc. v. Bowen, 728 F. Supp. 1172 (W.D. Pa. January 16, 1990).

Holy Cross Hospital v. Blue Cross and Blue Shield Association of New Mexico, PRRB Dec. No. 92-D14, February 14, 1992, Medicare and Medicaid Guide (CCH) ¶ 40,066, aff'd, HCFA Admin., April 13, 1992, Medicare and Medicaid Guide (CCH) ¶ 40,421.

Memorial Hospital/Adair County Health Center, Inc., v. Heckler, 829 F. 2d. 111 (D.C. Cir. September 18, 1987).

Upper Peninsula Home Nursing v. Blue Cross and Blue Shield Association/Blue Cross and Blue Shield United of Wisconsin, PRRB Dec. No. 97-D28, January 30, 1997, Medicare and Medicaid Guide (CCH) ¶ 45,062, declined rev. HCFA Admin., March 7, 1997.

6. Other:

- Dunham Study, 1978.
- Financial Accounting Standards Board statement No. 43, Accrued Liabilities
- Owner Salary Ranges Cost of Living increase factor communicated to Commerce Clearing House (CCH) and published in Medicare and Medicaid Guide (CCH) ¶ 5,623.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

Issue No. 1 - Patient Advocate/Community Relations Costs

The Board, after consideration of the facts, parties' contentions, and evidence presented, finds and concludes that the Intermediary properly reclassified 43.22% of the salaries and

employee benefits of the Patient Advocators and 100% of the Director of Community Relations salary and employee benefits to non-reimbursable cost centers. The Board finds that the Provider employed two Patient Advocators and one Director of Community Relations in the fiscal year at issue. The Intermediary reviewed the claimed costs for the three employees and determined through interviews and an analysis of the job descriptions that a significant portion of the claimed cost was geared toward patient solicitation and improvement of the Provider's patient utilization. The Board finds that the job descriptions and interviews of the appropriate personnel were reliable sources given the fact that the Provider did not submit any documentation to the contrary.

The Board notes that the Provider accepted the Intermediary's treatment disallowing 43.22% of the Patient Advocators expenses in the prior fiscal year (04/30/94). However, no evidence was submitted in the records by the Provider to support its contentions or disprove the Intermediary's determinations for the year at issue in this case (FYE 04/30/95).

The Board finds that it is appropriate to create a non-reimbursable cost center when there is a measurable amount of employee time and/or physical space dedicated to a specific non-reimbursable activity or function. The Board notes that HCFA Pub. 15-1 § 2302.8 defines a cost center as "[a]n organizational unit, generally a department or its subunit, having a common functional purpose for which direct and indirect costs are accumulated, allocated, and apportioned." The Board finds that the non-reimbursable activities of marketing and promoting referral sources properly fit within the definition of a separate cost center.

The Board also notes that HCFA Pub. 15-1 § 2328 provides that "[n]on-allowable cost centers to which general services costs apply should be entered on the cost allocation worksheets after all the General Service Cost Centers. General service costs would then be distributed to non-allowable cost centers in the routine 'step-down' process." The Board notes that this distribution helps ensure that all direct and indirect costs are accounted for in each cost center and that the Medicare program pays only its share of these costs.

Issue No. 2 - Accrued Expenses

The Board, after consideration of the facts, parties' contentions, and evidence presented, finds and concludes that there is no evidence in the record that the applicable accruals at the end of the year (12/31/94) for tax purposes were reversed out for proper accounting purposes. The Board finds nothing in the record to dispute the Intermediary's determination.

The Board notes the salaries in the current year were overstated, based on the Intermediary's comparison of the as-filed salaries claimed on the cost report to the actual salaries paid as reflected in the payroll tax returns. The Provider offered nothing in the record to contradict this or explain why such a variance existed. The Board notes that the

Intermediary allowed only the FUTA expenses that were actually paid based on the Provider's tax returns.

In summary, the Board finds that the Intermediary's determinations were proper given the documentation the Provider submitted. There was nothing in the record given by the Provider to support any of its contentions. The Provider failed to meet the requirements of 42 C.F.R. §§ 413.24 and 413.20, which provide in part:

> Financial Data and Reports
>
> (a) General. The principles of cost reimbursement will require that providers maintain sufficient financial records and statistical data for proper determination of costs payable under the program. Standardized definitions, accounting, statistics, and reporting practices, which are widely accepted in the hospitals and related fields are followed. Changes in these practices and systems will not be required in order to determine costs payable under the principles of reimbursement. Essentially, the methods of determining costs payable under Medicare involve making use of data available from the institution's basic accounts, usually maintained, to arrive at equitable and proper payment for services to beneficiaries.
>
> . . .
>
> (e) Continuing provider recordkeeping requirements.
>
> . . .
>
> (2) The provider must permit the intermediary to examine such records and documents as are necessary to ascertain information pertinent to the determination of the proper amount of program payments due.

Issue No. 3 - Pension Expense

The Board, after consideration of the facts, parties' contentions, and evidence presented, finds and concludes that the Intermediary properly disallowed unsupported pension expense.

The Board notes that the Intermediary requested documentation from the Provider to 1) show that the pension was a qualified plan in accordance with regulations IRS, 2) supply the Intermediary with an actuarial report to determine the liability/funding amount, and 3) document that the expense claimed was actually funded within the specified time frames. The Board finds nothing in the record to indicate that the Provider has ever supplied any of the documents mentioned above.

The Board finds that the Intermediary's determinations were proper given the paucity of documentation the Provider submitted. There was nothing in the record given by the

Provider to support any of its contentions. The Provider failed to meet the requirements of 42 C.F.R. §§ 413.20 and 413.24.

Issue No. 4 - Executive Compensation

The Board notes that the Intermediary has an obligation under the regulations and manual to develop information that can be used to evaluate the reasonableness of executive compensation. The Intermediary is required to obtain information on compensation paid by comparable institutions in the same geographical area. In accessing comparability, the Intermediary is to consider factors such as the duties and responsibilities of owners, size, and type of institution and its geographic location. A range at comparable institutions is to be established and used to determine reasonableness.

In this instant case, the Intermediary has relied upon the Dunham Survey performed in 1978, updated for inflation. The Board has previously found the surveys conducted by Dr. Dunham to be a reasonable method to develop comparable compensation rates. See Upper Peninsula Home Nursing v. Blue Cross and Blue Shield Association/Blue Cross and Blue Shield United of Wisconsin, PRRB 97-D28, January 30, 1997, Medicare and Medicaid Guide (CCH) ¶ 45,062, declined rev, HCFA Admin., March 7, 1997 and Harriet Holmes, supra.

The Provider did not contest the inflation update factor used by the Intermediary, it did however, dispute the Intermediary's failure to apply a 30% increase to Dunham Study results to account for employee benefits. The Board did not find sufficient evidence to substantiate either parties' contentions. Neither party supplied the actual Dunham Survey used in the record.
The Board finds that the burden of proof is on the Provider to submit any information that could have been substituted for the 1978 Dunham Survey, as proof that the 30% increase for employee benefits was, or was not already included in the Intermediary's calculation. Thus, the Board finds that the 1978 Dunham Survey, as used by the Intermediary absent any other study in the record, was a valid method to determine reasonableness.

The Board finds that, in this particular case, the only data source available for its use is Intermediary's 1978 Dunham Survey. The Board finds nothing in the record to determine where the Dunham Survey amounts came from. However, the Provider has failed to support its contention by not submitting its own version of reasonable compensation guidelines, which would have given the Board a basis for consideration in rendering its decision.

DECISION AND ORDER:

Issue No.1 - Patient Advocate/Community Relations Costs

The Intermediary's adjustments reclassifying salaries and employee benefits for Patient Advocates (43.22%) and Director of Community Relations (100%) to non-reimbursable cost centers were proper. The Intermediary's adjustments are affirmed.

Issue No. 2 - Accrued Expenses

The Intermediary's adjustments eliminating accrued salaries, accrued vacation, accrued employee benefits, Social Security and FUTA taxes were proper and are therefore, affirmed.

Issue No. 3- Pension Expense

The Intermediary's adjustment disallowing pension expense due to lack of documentation was proper. The Intermediary's adjustment is affirmed.

Issue No. 4 - Executive Compensation

The Intermediary's adjustment reducing executive compensation was correct. The Intermediary's adjustment is affirmed.

BOARD MEMBERS PARTICIPATING:

Irvin W. Kues
Henry C. Wessman, Esquire
Stanley J. Sokolove
Gary Blodgett, D.D.S.
Suzanne Cochran, Esquire

Date of Decision: August 28, 2002

FOR THE BOARD

Irvin W. Kues
Chairman