**PROVIDER REIMBURSEMENT REVIEW BOARD**
**DECISION**

**2022-D34**

**PROVIDERS –**
St. Vincent Mercy Medical Center et al.

**Provider Nos. –** Various
(*See* attached listing & Schedules of Providers)

**vs.**

**MEDICARE CONTRACTOR –**
CGS Administrators, LLC – J15 MAC;
National Government Services, Inc.; WPS
Government Health Administrators

**HEARING DATE –**
December 1, 2020

**Fiscal Year Ending** –
Various 2009-2016

**Case Nos. –** 18-0890, 18-0896, 18-0897, 18-0898, 20-0275G, 20-0621G

**INDEX**

## ISSUE STATEMENT

Whether it is appropriate to offset the tuition revenue for Nursing and Allied Health ("NAH") programs on Worksheet A-8 or whether it is appropriate to offset the tuition revenue only after the stepdown process.[1]

## DECISION

After considering Medicare law and regulations, the arguments presented, and the evidence admitted, the Provider Reimbursement Review Board ("Board") finds that it was appropriate for the Medicare Contractors to offset tuition revenue for NAH programs on Worksheet A-8 for the fiscal years at issue.

## INTRODUCTION

St. Vincent Mercy Medical Center and several other providers[2] (collectively the "Providers") offer nursing educational programs and/or allied health professional education programs. The Providers dispute the method used by Medicare contractors[3] assigned to them ("Medicare Contractors")[4] to calculate, for the fiscal years at issue, the direct and indirect costs attributable to the NAH programs that are eligible for Medicare reimbursement. The fiscal years at issue include 2009, 2010, and 2012 to 2016.

Each Provider timely appealed the Medicare Contractor's final determinations and has met the jurisdictional requirements for a hearing before the Board.[5] On September 1, 2020, the Board approved a *consolidated* hearing for the six above-captioned cases which is comprised of four individual provider cases and two optional groups.

A *consolidated* video hearing was held on December 1, 2020. The Providers were represented by Mark D. Polston, Esq., Christopher P. Kenny, Esq. and Alek W. Pivec, Esq. of Verrill Dana, LLP. The Medicare Contractors were represented by Edward Y. Lau, Esq. and Joseph J. Bauers, Esq. of Federal Specialized Services.

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[1] Transcript of Proceedings (hereinafter "Tr.") at 5.
[2] *See* attached Case Listing and Schedules of Providers.
[3] CMS' payment and audit functions under the Medicare program were historically contracted to organizations known as fiscal intermediaries ("FIs") and these functions are now contracted with organizations known as Medicare administrative contractors ("MACs"). The term "Medicare contractor" refers to both FIs and MACs as appropriate and relevant.
[4] CGS Administrators, LLC, National Government Services, Inc. and WPS Government Health Administrators are the Medicare contractors involved in this group of appeals.
[5] In the Medicare Contractor's Post Hearing Brief at 5 (March 1, 2021), the Medicare Contractor raised jurisdictional challenges: (1) in Case No. 20-2075 for Beth Israel Medical Center (Prov. No. 33-0169) for the fiscal years ending ("FYE") December 31, 2012 and December 31, 2013; and (2) in Case No. 20-0621G for The Nebraska Medical Center (Prov. No. 20-0013) for FYE June 30, 2016.

## STATEMENT OF FACTS AND PROCEDURAL HISTORY

This appeal concerns the Providers' contention that the published cost report instructions for Worksheet A-8, Line 19, are in error when they state:

> For each . . . [Nursing and Allied Health Education] program on Worksheet A, line 20, and its subscripts, and Worksheet A, line 23, and its subscripts, enter the revenue adjustments (for tuition, fees, books, etc.) to be applied against total allowable costs that are directly related to the approved NAHE activities. Subscript this line to separately report the revenue offset for each NAHE program reported on line 20 and line 23.[6]

The Providers maintain that the offsets for tuition revenue and student fees should be made after indirect costs are allocated, using Worksheet D Parts III and IV, which follows the allocation of indirect costs on Worksheet B Part I. The Providers cite to 42 C.F.R. § 413.85(d)(2) as the guiding regulation for this issue.

### *A. Allied Health Education Programs*

From the inception of the Medicare program in 1965, certain medical education expenses have been reimbursed on a reasonable cost basis.[7] Both the House and Senate Committee reports, accompanying the 1965 legislation,[8] suggest that Congress favored including medical educational expenses as allowable medical education costs under the Medicare program. The following statements from Congressional committee reports address the reimbursement of medical education costs as allowable expenses under the Medicare program and reflect Congressional inclination regarding reimbursement of medical education expenses:

> Many hospitals engage in substantial educational activities, including the training of medical students, internship and residency programs, the training of nurses, and the training of various paramedical personnel. Educational activities enhance the quality of care in an institution, and it is intended, until the community undertakes to bear such education costs in some other way, that a part of the net cost of such activities (including stipends of trainees as well as compensation of teachers and other costs) should be considered as an element in the cost of patient care, to be borne to an appropriate extent by the hospital insurance program.[9]

Significantly, these reports specifically list nursing and paramedical (*i.e.*, NAH) education expenses as a type of medical education activity that "should be considered as an element in the

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[6] Provider Reimbursement Manual, CMS Pub. No. 15-2 (hereinafter "PRM 15-2") § 4016.
[7] *See* 42 U.S.C. § 1395x(v)(1)(A); 42 C.F.R. § 405.421 (1966); 57 Fed. Reg. 43659, 43661 (Sept. 22, 1992).
[8] Social Security Amendments of 1965, Pub. L. No. 89-97, 79 Stat. 286 (1965).
[9] S. Rep. No. 89-404, at 36 (1965); H.R. Rep. No. 89-213, at 32 (1965).

cost of patient care, to be borne to an appropriate extent by the hospital insurance program [*i.e*., the Medicare program]."[10]

On November 22, 1966, the Secretary published a final rule promulgating regulations at 20 C.F.R. § 405.421 addressing when the costs of educational activities are allowable under the Medicare program.[11] In 1975, the Secretary clarified that an approved nursing or allied health education program had to be operated by a provider for its costs to be allowable as the costs of approved educational activities.[12] In 1977, the Secretary redesignated the regulation as 42 C.F.R. § 405.421 without altering or amending subsection (c) of that regulation.[13]

In 1983, Congress enacted the Medicare inpatient prospective payment system ("IPPS") under which the Medicare program reimburses hospitals for the "operating costs of inpatient hospital services" at a fixed, predetermined rate.[14] Significantly, Congress excluded "approved educational activities," such as nursing and allied health education activities, from IPPS.[15] On September 1, 1983, the Secretary issued an interim final rule ("September 1983 Interim Final Rule") to implement the IPPS.[16] Consistent with the statute, the September 1983 Interim Final Rule excluded certain approved medical education activities, such as nursing and allied health education activities, from hospital operating costs under IPPS, and continued to pay these costs on a reasonable cost or "pass-through" basis.[17] On September 30, 1986, the Secretary redesignated 42 C.F.R. § 405.421 as 42 C.F.R. § 413.85 without altering or amending subsection (c) of that regulation.[18]

Through the Omnibus Budget Reconciliation Act of 1989 ("OBRA-89")[19] and the Omnibus Budget Reconciliation Act of 1990 ("OBRA-90"),[20] Congress revised the educational cost rules as they applied to nursing and allied health education expenses. In § 6205(a) of OBRA-89, Congress created a *temporary* category of certain "hospital-based nursing schools" and allowed such hospitals to claim the costs incurred in training nursing students in a hospital-based nursing school as pass-through costs. This *temporary* category was effective for cost reporting periods beginning on or after December 19, 1989 and on or before the date the Secretary issued a final rule that addressed the payment of costs of approved nursing and allied health education programs.[21] Congress, in OBRA-89 § 6205(a)(2), specifically directed the Secretary to issue regulations clarifying the criteria for reasonable cost reimbursement of nursing education costs to include:

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[10] *Id.*
[11] 31 Fed. Reg. 14808,14814 (Nov. 22, 1966). *See also* Exhibit C-9
[12] Provider Reimbursement Manual, CMS Pub. No. 15-1 (hereinafter "PRM 15-1") § 404.2. *See also* 66 Fed. Reg. 3357, 3359 (Jan. 12, 2001).
[13] 42 Fed. Reg. 52826 (Sept. 30, 1977).
[14] *See* Social Security Amendments of 1983, Pub. L. No. 98-21, 97 Stat. 65, 152 § 601(e) (1983); 42 U.S.C. § 1395ww(d).
[15] 97 Stat. at 149 (codifying 42 U.S.C. § 1395ww(a)(4) which excluded "approved education activities" from the definition of "operating costs of inpatient hospital services").
[16] 48 Fed. Reg. 39752 (Sept. 1, 1983).
[17] *See id*. at 39797, 39811, 39844 (amending 42 C.F.R. § 405.421). *See also* 42 U.S.C. § 1395ww(a)(4).
[18] 51 Fed. Reg. 34790, 34790-34791, 34813-34814 (Sept. 30, 1986).
[19] Pub. L. No. 101-239, 103 Stat. 2106, 2243 (1989).
[20] Pub. L. No. 101-508, 104 Stat. 1388, 1388-39 – 1388-40 (1990).
[21] OBRA-89 § 6205(a)(2). *See also* Exhibit P-7.

> (i) the relationship required between an approved nursing . . . education program and a hospital for the program's costs to be attributed to the hospital;
>
> (ii) the types of costs related to nursing . . . education programs that are allowable by medicare;
>
> (iii) the distinction between costs of approved educational activities . . . [eligible for pass-through reimbursement] and educational costs treated as operating costs of inpatient hospital services; and
>
> (iv) the treatment of other funding sources for the program.[22]

Congress further mandated that the Secretary issue regulations reflecting these statutory requirements by July 1, 1990 and that these regulations "shall not be effective prior to October 1, 1990, or 30 days after publication of the final rule in the Federal Register, whichever is later."[23]

On January 12, 2001, the Secretary issued a final rule ("2001 Final Rule")[24] promulgating the regulation at 42 C.F.R. § 413.85 to implement the OBRA-89 and OBRA-90 revisions to the educational cost rules.[25] The Secretary subsequently revised these regulations through final rules published on August 1, 2003 and August 11, 2004 ("2003 Final Rule" and "2004 Final Rule" respectively).[26] As a result of those final rules, the regulations at 42 C.F.R. § 413.85(d) (2009) set forth the applicable standards for reimbursing the reasonable cost of nursing and allied health educational activities under the Medicare program stating, in relevant part:

> (d) *General payment rules.* (1) Payment for a provider's **net cost** of nursing and allied health education activities is determined on a reasonable cost basis, subject to the following conditions and limitations:
>
> (i) An approved educational activity —
>
> (A) Is recognized by a national approving body or State licensing authority as specified in paragraph (e) of this section;
>
> (B) Meets the criteria specified in paragraph (f) of this section for identification as an operator of an approved education program.

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[22] *Id*. § 6205(b)(2)(C).
[23] *Id*. § 6205(b)(2)(B)(iii).
[24] 66 Fed. Reg. 3358 (Jan. 12, 2001).
[25] 57 Fed. Reg. 43659 (Sept. 22, 1992).
[26] The 2003 and 2004 Final Rules are located at 68 Fed. Reg. 45346 (Aug. 1, 2003) and 69 Fed. Reg. 48916 (Aug. 11, 2004), respectively.

> (C) Enhances the quality of inpatient care at the provider.
>
> (ii) The cost for certain nonprovider-operated programs are reimbursable on a reasonable cost basis if the programs meet the criteria specified in paragraph (g)(2) of this section.
>
> (iii) The costs of certain nonprovider-operated programs at wholly owned subsidiary educational institutions are reimbursable on a reasonable cost basis if the provisions of paragraph (g)(3) of this section are met.
>
> (2) *Determination of net cost.* (i) Subject to the provisions of paragraph (d)(2)(iii) of this section, the net cost of approved educational activities is determined by **deducting the revenues that a provider receives from tuition and student fees from the provider's total allowable educational costs that are directly related to approved educational activities.**
>
> (ii) A provider's total allowable educational costs are those costs incurred by the provider for trainee stipends, compensation of teachers, and other costs of the activities as determined under the Medicare cost-finding principles in §413.24. **These costs do not include** patient care costs, **costs incurred by a related organization**, or costs that constitute a redistribution of costs from an educational institution to a provider or costs that have been or are currently being provided through community support.
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> * * * *
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> (iv) Net costs are subject to apportionment for Medicare utilization as described in §413.50.[27]

### *B. Cost Report Data and Cost Finding*

Under IPPS, Providers are required to furnish cost data to Medicare contractors in order to receive program payments.[28] Medicare contractors must be allowed to examine "records and documents as are necessary to ascertain information pertinent to the determination of the proper amount of program payments due."[29]

The cost data that providers furnish when seeking reimbursement must be according to one of several approved cost-finding methods, as explained at 42 C.F.R. § 413.24 (2009):

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[27] (Italics emphasis in original and bold emphasis added.)
[28] 42 C.F.R. § 413.20(d)(1).
[29] *Id*. § 413.20(d)(2).

> (a) *Principle.* Providers receiving payment on the basis of reimbursable cost must provide adequate cost data. This must be based on their financial and statistical records which must be capable of verification by qualified auditors. The cost data must be based on an approved method of cost finding and on the accrual basis of accounting.

The Provider Reimbursement Manual, Part II ("CMS Pub 15-2"), § 3610 provides instructions for reporting the costs of Allied Health Education Programs on Schedule A of the cost report and state, in relevant part:

> Line 24— this line is used for a hospital or subprovider which operates an approved paramedical education program that meets the criteria of 42 CFR 413.85 and 412.113(b). Establish a separate cost center for each paramedical education program (e.g., one for medical records or hospital administration). If additional lines are needed, subscript line 24. If the direct costs are included in the costs of an ancillary cost center, reclassify them on Worksheet A-6 to line 24. Appropriate statistics are required on Worksheet B-1 to ensure that overhead expenses are properly allocated to this cost center.

These instructions require that, prior to allocating overhead costs to the revenue producing cost centers, a provider must make appropriate reclassifications and adjustments to its costs. While Worksheet A-6 is used to reclassify costs between cost centers on the cost report, Worksheet A-8 is used to adjust both a provider's revenue and non-revenue producing cost centers. The cost report instructions for completing Worksheet A-8 are found at CMS Pub 15-2, § 4016[30] which states, in relevant part:

> Types of adjustments entered on this worksheet include (1) those needed to adjust expenses to reflect actual expenses incurred; (2) ***those items which constitute recovery of expenses through sales, charges, fees, etc.;*** (3) those items needed to adjust expenses in accordance with the Medicare principles of reimbursement; and (4) those items which are provided for separately in the cost apportionment process.[31]

Cost report Worksheet B-1 is used to allocate General Services costs and is designed to accommodate the step-down method of cost finding.[32] All the Providers in this appeal used the step-down method to allocate costs. The regulation at 42 C.F.R. § 413.24(d)(1) (2009) describes the step-down method of cost finding as:

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[30] CMS Pub. 15-2 § 3613 per CMS-2552-96 instructions.

[31] (Emphasis added.)

[32] The statistical basis shown at the top of each column on Worksheet B-1 is the recommended basis of allocation of the cost center indicated. If a different basis of allocation is used, the provider must indicate the basis of allocation actually used at the top of the column and subject to the provisions of PRM 15-1 § 4020.

> (1) *Step-down method*. This method recognizes that services rendered by certain nonrevenue-producing departments or centers are utilized by certain other nonrevenue-producing centers as well as by the revenue-producing centers. All costs of nonrevenue-producing centers are allocated to all centers that they serve, regardless of whether or not these centers produce revenue. The cost of the nonrevenue-producing center serving the greatest number of other centers, while receiving benefits from the least number of centers, is apportioned first. Following the apportionment of the cost of the nonrevenue-producing center, that center will be considered "closed" and no further costs are apportioned to that center. This applies even though it may have received some service from a center whose cost is apportioned later. Generally, if two centers furnish services to an equal number of centers while receiving benefits from an equal number, that center which has the greatest amount of expense should be allocated first.

In addition, § 413.24(d)(2)-(3) specifies that a provider can elect the following alternative allocation methodologies, in lieu of the default step-down methodology:

> *(2) Other Methods.*
>
> (i) *The double-apportionment method*.[33] The double-apportionment method may be used by a provider **upon approval of the intermediary**. This method also recognizes that the nonrevenue-producing departments or centers furnish services to other nonrevenue-producing centers as well as to revenue-producing centers. A preliminary allocation of the costs of non-revenue-producing centers is made. These centers or departments are not ‘‘closed’’ after this preliminary allocation. Instead, they remain ‘‘open,’’ accumulating a portion of the costs of all other centers from which services are received. Thus, after the first or preliminary allocation, some costs will remain in each center representing services received from other centers. The first or preliminary allocation is followed by a second or final apportionment of expenses involving the allocation of all costs remaining in the nonrevenue-producing functions directly to revenue-producing centers.
>
> (ii) *More sophisticated methods.* A more sophisticated method designed to allocate costs more accurately may be used by the provider **upon approval of the intermediary**. However, having elected to use the double-apportionment method, the provider may

[33] In PRM 15-1 § 2306.3, CMS provides detailed instructions for the double apportionment methods which include: (a) double-apportion-accumulative; and (b) double apportionment-non-accumulative.

> not thereafter use the step-down method **without approval of the intermediary**. **Written request for the approval must be made on prospective basis and must be submitted before the end of the fourth month for the prospective reporting period**. Likewise, once having elected to use a more sophisticated method, the provider may not thereafter use either the double-apportionment or step-down methods without similar request and approval.
>
> (3) *Modified cost finding for providers using the Combination Method for reporting periods beginning after December 31, 1971*. This method differs from the step-down method in that services furnished by nonrevenue-producing departments or centers are allocated directly to revenue-producing departments or centers even though these services may be utilized by othernonrevenue-producing departments or centers. In the application of this method the cost of nonrevenue-producing centers having a common basis of allocation are combined and the total distributed to revenue-producing centers. All nonrevenue-producing centers having significant percentages of cost in relation to total costs will be allocated this way. The combined total costs of remaining nonrevenue-producing costs centers will be allocated to revenue-producing cost centers in the proportion that each bears to total costs, direct and indirect, already allocated. The bases which are to be used and the centers which are to be combined for allocation are not optional but are identified and incorporated in the cost report forms developed for this method. Providers using this method must use the program cost report forms devised for it. Alternative forms may not be used without prior approval by CMS based upon a written request by the provider submitted through the intermediary.[34]

The provider can elect to change the order of allocation and/or allocation statistics, as appropriate, for the current cost reporting period if a request is received by the Medicare contractor, in writing, 90 days prior to the end of that reporting period and the Medicare contractor approves that request.[35] The request to change allocation methodology *must* include supporting documentation and an explanation of why the alternative methodology should be used.[36] Additionally, the change *must* be shown to ***more*** *accurately* allocate the overhead or should demonstrate simplification in maintaining the changed statistics will be less costly.[37]

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[34] 42 C.F.R § 413.24(d)(2)-(3) (footnote added).
[35] PRM 15-1 § 2313.
[36] *Id.*
[37] *Id.*

### *C. Providers' Treatment of Nursing and Allied Education Program Costs on Their Cost Reports*

This decision encompasses four (4) individual cases involving St. Vincent Mercy Medical Center over four fiscal years, as well as two (2) optional group cases.[38] During the cost reporting periods under appeal, the Providers engaged in approved NAH activities in various programs and received tuition from students training in those programs. As described below, there are differences in how the tuition and student fees were addressed/reported on the cost reports for each Provider.

For the four individual appeals involving St. Vincent Mercy Medical Center ("St. Vincent"), this decision covers reporting periods ending December 31, 2009, 2010, 2014, and 2015. For 2009 and 2010, St. Vincent was issued Notices of Program Reimbursement ("NPRs") by the Medicare Contractor for cost reports on which St. Vincent reported its tuition as an offset on Worksheet A-8; the Medicare Contractor did not adjust the tuition reported. Subsequently, "[a]t St. Vincent's request, . . . [the Medicare Contractor] issued revised NPRs ["RNPRs"] for both periods . . . . In the revised NPRs, the . . . [Medicare Contractor] made upward adjustments to the accumulated costs of the NAH cost center on Worksheet B-1 in an amount equal to the tuition that were reported on Worksheet A-8 in each year."[39] The Medicare Contractor issued second RNPRs reversing these adjustments, based on guidance from CMS, noting that "all tuition must be reported as an adjustment on Worksheet A-8."[40] For 2014 and 2015, St. Vincent submitted its cost reports with tuition revenue as post step-down adjustments on Worksheets D, Part III and IV, but the Medicare Contractor removed those adjustments and offset the tuition on Worksheet A-8 in the final NPRs.[41]

The optional group under Case No. 20-0275G involves two Providers, each appealing two fiscal years. First, Signature Health Brockton Hospital ("Signature") appealed cost reporting periods ending September 30, 2014 and 2015. In each fiscal year, Signature's NAH cost centers had no or inequitably low accumulated costs. Signature ultimately "made manual adjustments to Worksheets E Part A, E, Part B and E-3 Part II to ensure that it was reimbursed for the A&G costs that should have been allocated to its NAH cost centers."[42] The Medicare Contractor removed these manual adjustments from Signature's cost reports for FYs 2014 and 2015. The second Provider in Case No. 20-0275G, Mount Sinai Beth Israel Medical Center ("Mount Sinai"), is appealing cost reporting periods ending December 31, 2012 and 2013. For each fiscal year, Mount Sinai "reported its tuition revenue on Worksheet A-8....[and] . . . did not attempt to report its tuition revenue as a post step-down adjustment because CMS Transmittal 12 indicated that . . . [the Medicare Contractor] was without discretion to grant that relief.[43] These facts are consistent for the following two Providers in the remaining optional group under Case No.

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[38] *See* attached Schedules of Providers for a full listing of the Providers in each group case. The Providers shall be referenced as "St. Vincent" or "Providers" throughout the decision.
[39] Providers' Consolidated Final Position Paper (hereinafter "Providers' FPP") at 15-16 (Oct. 8, 2020).
[40] *Id.* at 16.
[41] *Id.* at 16.
[42] *Id.* at 17.
[43] *Id.* at 19.

20-0621G: the Nebraska Medical Center ("Nebraska") and Bryan Medical Center ("Bryan"), which are appealing from cost reporting periods ending June 30, 2016 and December 31, 2016, respectively. Bryan did file a protested amount for this issue, which was adjusted by the Medicare Contractor.[44]

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

The Providers contend that the tuition and student fees should be removed from total costs based on 42 C.F.R. § 413.85(d)(2)(i) and that offset should be made after the indirect costs are allocated on Worksheet B Part I, using Worksheet D Parts III and D Part VI. In addition, they contend that the Medicare Contractor's methodology for calculating net costs is arbitrary and capricious because it could produce results such as no allocation of Administrative & General ("A&G") costs. Additionally, the Providers argue that the cost report instructions permit post step-down adjustment for NAH tuition, and that the Medicare Contractor's methodology violates the notice and comment requirements of the Medicare statute.

The Providers argue that the Medicare Contractors' method of offsetting tuition and student fees on Worksheet A-8 did not follow the specific order mandated by 42 C.F.R. § 413.85(d)(2). The Providers argues that "the plain text of the regulation, [which] says that tuition must be deducted from total allowable educational costs directly related to approved educational activities. The regulation defines total allowable educational costs as "costs incurred by the provider for trainee stipends, compensation of teachers, and other costs of the activities as determined under the Medicare cost-finding principals in [42 C.F.R] § 413.24."[45] According to the Providers, the regulation requires that indirect costs be included as part of a provider's total allowable educations costs before tuition and student fees are offset. [46]

The Providers also argue that the Medicare Contractors' methodology of offsetting tuition and student fees on Worksheet A-8 "is [] arbitrary and capricious because it produces irrational results."[47] The Providers further argue:

> In particular, if a hospital received tuition revenue for its NAH activities, the . . . [Medicare Contractors'] methodology reduces the amount of overhead costs allocated to the NAH cost centers. But the fact that a provider received tuition to cover some of the costs of its NAH activities does not mean those activities have incurred less in overhead costs. Furthermore, under the . . . [Medicare Contractors'] methodology, if the tuition that the hospital receives for its NAH activities exceeds the direct costs of those activities, then the NAH cost center would not be allocated any overhead costs at all.[48]

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[44] *Id.* at 18-19.
[45] *Id.* at 21-22.
[46] *Id.* at 22.
[47] *Id.* at 39.
[48] *Id.* at 3.

The Providers claim the "cost report instructions acknowledge that sometimes it is necessary to adjust certain cost centers after the step-down process is complete in order to more accurately calculate the costs of a cost center."[49] These post step down adjustments are "reported on Worksheet B-2 [and] flow through to Worksheets D, Part III and IV [of the Medicare cost report] . . . ."[50] Providers are instructed to enter on Worksheet B-2, "any additional adjustments that are required under the Medicare principles of reimbursement."[51] The Providers state that post step-down adjustments reported on Worksheet B-2 for NAH cost flow through to Worksheet D, Parts III and IV, which is where NAH costs are apportioned for Medicare utilization. They state that providers were "permitted to use Worksheet B-2 to make adjustment to the *total* costs---after calculating both direct and indirect costs---of their NAH programs to report the *net* costs of these programs on their cost reports, just as Medicare's NAH regulation requires."[52]

The Providers continue by alleging that, "in 2017, CMS amended the instructions to Worksheet B-2 to prohibit providers from applying post step-down adjustments for tuition and student fees to the total allowable costs of NAH activities."[53] This amendment required providers to use Worksheet A-8 to offset tuition and student fees and prohibited the use of Worksheet B-2 to offset the tuition and student fees after the all indirect costs are allocated. The Providers argue that this is a change in policy and does not follow 42 C.F.R. 413.85(d)(2)(1) which "states that 'the net cost of approved educational activities is determined by deducting the revenues that a provider receives from tuition from the *total* allowable educational costs that are directly related to approved educational activities.'"[54] The Providers also cite to § 1395hh(a)(2) which states: "No rule, requirement, or other statement of policy (other than a national coverage determination) that establishes or changes a substantive legal standard governing the scope of benefits, the payment for services, or the eligibility of individuals, entities, or organizations to furnish or receive services or benefits under this subchapter shall take effect unless it is promulgated by the Secretary by regulation. . . ."[55]

The Medicare Contractor disagrees with the Providers' interpretation of 42 C.F.R. § 413.85 and states that the "tuition revenue is deducted from total allowable educational costs that are directly related to approved educational activities and which do not include patient care costs."[56] The Medicare Contractor notes that, "in the entire nursing and allied health regulation [at 42 C.F.R. § 413.85], there is included only one reference to indirect cost and that is found under Paragraph (b)(2)... which states 'this section does not address Medicare payments for the direct and indirect costs of graduate medical education.'"[57] The Medicare Contractor maintains that, in order to arrive at the Providers' interpretation of the regulation, it has to ignore two key phrases: "(1) costs that are directly related to approved educational activities and (2) which do not include

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[49] *Id.* at 12.
[50] *Id.* at 35.
[51] *Id.* at 12-13.
[52] *Id* at 13.
[53] *Id. See also* CMS Transmittal 12 (Nov. 17, 2017) (copy at Exhibit P-5).
[54] Providers' FPP at 20.
[55] *Id* at 37. *See also* 42 U.S.C. § 1395hh(a)(2).
[56] Tr. at 30.
[57] *Id*. at 31.

patient care costs."[58] The Medicare Contractor argues that the Providers' alternate methodology ignores the regulations and the cost report instructions. The Medicare Contractor states that the providers' methodology, through the Worksheet B, Part I, stepdown process, allocates additional costs to the NAH programs *before* offsetting revenue.[59]

Regarding the Providers' argument that organ acquisition revenue offset is completed after the allocation of indirect costs on Worksheet B, Part I, the Medicare Contractor points out that organ acquisition and allied health have their own specific regulations.[60] The Medicare Contractor asserts that the individual and collective adjustments are proper and consistent with the controlling regulation[61] for NAH and the cost report instructions.[62]

The Board finds that the Providers' position that offsetting tuition and student fees on Worksheet A-8 violates the order of allocation as required by 42 C.F.R. § 413.85(d)(2)(i) is misplaced. The Providers argue that the revenue for tuition and student fees are to be offset against total allowable cost and, therefore, that this offset must occur after all indirect costs are allocated on Worksheet B, Part I. The Providers' point out that offsetting tuition and student fees on Worksheet A-8 results in less accumulated cost for the NAH cost centers. Because the final accumulated cost (after reclasses and offsets) is the allocation basis for allocating A&G costs on Worksheet B-1, then reduced costs due to offsets on Worksheet A-8 *will result* in less A&G costs being allocated to the NAH programs on Worksheet B, Part I.

The Board agrees that the intent of the regulation is to offset tuition and student fees against total costs. However, the Board disagrees that making the offset on Worksheet A-8 is erroneous and will result in irrational results. Under the default step-down overhead allocation methodology, the Providers may have received a lesser A&G allocation. However, the Board notes that the Providers could have requested to use an alternate methodology for allocation of A&G costs (*i.e.*, a methodology other than the default step- down methodology) and did not do so.[63] Per 42 C.F.R. § 413.24(d)(2)-(3), a provider has the option to choose the double-apportionment method, more sophisticated methods, or a combination method for allocating indirect costs. Consistent with that regulation, PRM 15-1 § 2310 provides the following guidance to providers seeking to use more sophisticated methods:

> A more sophisticated method of cost finding designed to allocate cost more accurately may be used by the provider (other than a free-standing home health agency) ***upon approval*** *of the intermediary*. A more sophisticated method is generally dependent on computerized programs to produce the allocation results; the approval by the intermediary pertains to the cost finding methodology, not the computer system. The computer system must

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[58] *Id.*
[59] *Id.* at 34.
[60] *Id*. at 36.
[61] 42 C.F.R. § 413.85.
[62] Tr. at 33.
[63] *See* 42 C.F.R. § 413.24; PRM 15-1 § 2310.

> be reviewed and approved by . . . [CMS] before an intermediary can accept it in lieu of . . . [CMS] forms.[64]

Thus, in order to use a more sophisticated method, a provider must obtain approval from the Medicare contractor. PRM 15-1 § 2313 describes the approval process and specifies that a provider must submit a written request for an allocation change to the intermediary 90 days prior to the end of the cost reporting period for which the request applies.[65] Significantly, this approval process is consistent with that stated in 42 C.F.R. § 413.24(d)(2)-(3).

CMS has provided in both the regulation (42 C.F.R. § 413.24) and the cost reporting instructions (PRM 15-1 § 2313) for the possibility of alternate methods of allocation, *upon request*. The fact that a provider has the right to request alternate allocation methods, it can be inferred that CMS recognizes that the default methodology, as used by the Providers in this appeal, may not always result in the most accurate allocation of indirect cost. However, the burden is on the Providers to identify and elect an alternate allocation methodology that would more accurately allocate indirect costs, ***and*** to properly request and obtain approval to use such a methodology. Had the Providers timely considered using a different allocation methodology, they could have potentially identified an appropriate allocation methodology that resulted in a more accurate allocation of A&G costs and then sought the Medicare Contractor's approval of that alternative allocation methodology consistent with PRM 15-1 § 2313 and 42 C.F.R. § 413.24(d)(2)-(3). However, they did not make such a request.

The Providers point to the treatment of organ acquisition revenue on the cost report (where it is reported on Worksheet D-4, Parts III and IV, *after* the allocation of indirect costs) in support of their argument regarding where on the cost report the offset of NAH tuition and student fees should occur.[66] In contrast to organ acquisition revenue, the cost report instructions specify that the NAH revenue offset is reported on Worksheet A-8 *before* the allocation of indirect costs. Any potential appeal of the Providers argument is quickly dispelled upon close examination of the different rules that governing payment of NAH and transplant programs. For NAH education costs, 42 C.F.R. § 413.85(d)(2)(ii) explains that Medicare's intent is to pay ***only*** for nursing or allied health costs that were *not* covered through community support and do *not* constitute a redistribution of costs from an educational facility.[67] Because the NAH tuition and student fees cannot be tied to a specific payor (*e.g.*, Medicare), they are offset on Worksheet A-8, *before* indirect costs are allocated. In contrast, the total costs to acquire an organ for transplant *can be tied* to specific payors (*e.g.*, Medicare and all other payors). As a result, organ acquisition costs are computed on Worksheet D-4, Line 61, *after* indirect costs are allocated. In fact, the cost

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[64] (Emphasis added.)

[65] Specifically PRM 15-1 § 2313 provides: "When a provider wishes to change its statistical allocation basis for a particular cost center and/or order in which the cost centers are allocated because it believes the change will result in more appropriate and more accurate allocations, the provider must make a written request to its intermediary for approval of the change ninety (90) days prior to the end of that cost reporting period.... The provider must include with the request all supporting documentation to establish that the new method is more accurate."

[66] Providers' FPP at 32-33.

[67] 42 C.F.R. § 413.85(d)(2)(ii) (stating that a provider's total allowable educational costs "do *not* include . . . costs that constitute a redistribution of costs from an educational institution to a provider or *costs that have been or are currently being provided through community support*." (emphasis added).

reporting instruction for Worksheet D-4, line 61 require that the *revenue received* for organs acquired may **not** exceed the *cost* of acquiring those organs.[68] The cost reporting instructions for Worksheet D-4, Line 63 detail how to determine the organ acquisition costs related just to Medicare.[69] Because one can specifically identify both the cost of Medicare organ acquisition and the revenue from Medicare organs sold, it is possible to arrive at the *net* organ acquisition reimbursable cost on Worksheet D-4, Line 67.[70] Therefore, the reimbursement methods for organ acquisition and NAH are not similar, much less the same. Accordingly, the Providers' reliance on their superficial similarities is misplaced.

The Providers also attempt a similar comparison between the NAH tuition offsets and revenue received when selling drugs to patients in the Providers' regular patient care operations. In their Position Paper, the Providers argue "[s]imilar to the proceeds that the hospital receives for the drug, the tuition that providers receive for providing NAH services should not be reported on Worksheet A-8 because it does not restate the true cost of the programs."[71] The Providers are ignoring the fact that Drugs Charged to Patients (and Organ Acquisition, in our earlier discussion) are Patient Care services, not overhead costs. Both Drugs Charged and Organ Acquisition have specific cost report lines upon which their costs are to be reported, and *more importantly*, the related patient care charges/revenue are reported for those cost centers on Worksheet C. This results in a cost-charge ratio, which is used in an effort to determine the amount of Medicare reimbursement. Contrary to treatment on the cost report of Patient Care cost centers, NAH cost centers are treated the same as Overhead (General Service) cost centers. The Medicare Contractors raised this issue in their Position Paper, stating: "Such a treatment of NAH revenue is consistent with the treatment of certain revenues for other nonrevenue-producing cost centers included in the General Service cost centers, which include cafeteria revenues for employees and guess [sic]...., revenues for sale of medical records..., revenues for sale of medical supplies other than patients...etc."[72] In fact, revenue earned for the sale of drugs to other than patients is also properly offset on Worksheet A-8.[73] The differentiating factor is whether, or not, the revenue is related to the provision of care to the provider's patients. When it is not patient-care related revenue, it is considered a recovery of cost and the cost report instructions at PRM 15-2 § 4016 direct the offset of revenue as a recovery of cost, via Worksheet A-8.[74] Similar to a cafeteria, the NAH cost centers are "General Service" cost centers, not revenue-producing (patient care) cost centers. The Providers' are attempting to minimize the similarity between cafeteria (which also is clearly directed to offset revenue via Worksheet A-8) and NAH cost centers while attempting to create a similarity between the NAH cost center and

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[68] PRM 15-2 § 4028.3 (CMS-2552-10 instructions stating: "This amount must be equal to or greater than the amount reported on line 66 (revenues for organs sold).").
[69] *Id*. (CMS-2552-10 instructions).
[70] *Id*.
[71] Providers' FPP at 36.
[72] Medicare Contractors' Consolidated Final Position Paper (hereinafter "Medicare Contractors' FPP") at 8 (Nov. 6, 2020).
[73] An example of this can be found on the Brockton cost report Worksheet A-8, included as Exhibit C-27. On page 134, line 17 (Sale of drugs to other than patients), the provider has offset $1,559,784, which is noted as "basis B" – which identifies a revenue offset.
[74] PRM 15-2 § 4016 (stating: "Types of adjustments entered on this worksheet [*i.e*., Worksheet A-8] include...(2) those items which constitute recovery of expenses through sales, charges, fees, etc.").

the Drugs Charged cost center. This attempt is defeated by the cost report's clear structure that requires the reporting of all NAH programs with the General Service cost centers (such as cafeteria, which are clearly directed to offset revenue on Worksheet A-8) and the reporting of Drugs Charged to Patients (and Organ Acquisition) with *patient-care/revenue producing* cost centers (which report their patient care revenue on Worksheet C). Unlike the Drugs Charged cost center, NAH programs do ***not*** produce patient care revenue. However, NAH programs do provide general services to patient care areas and are properly treated as overhead cost centers, providing overhead to other cost centers. This function is similar to the cafeteria cost center and, accordingly, the similar handling of revenue offsets (via Worksheet A-8) is reasonable.[75]

With regard to the A&G overhead costs allocated to NAH, the Board finds that these costs must be directly related to NAH. The phrase "total allowable educational costs that are directly related to approved educational activities"[76] has a very specific meaning that was articulated in the Federal Register. On September 22, 1992, as directed by Congress, CMS[77] proposed its initial rules to set its policy for Medicare payment of the costs associated with approved NAH education programs. In the preamble to these proposed rules, CMS discussed allowable NAH costs:

> Section 4004(b)(1) of Public Law 101– 508 also requires that we define the clinical training costs that would be allowable. *We are proposing to define these costs as* ***incremental*** *costs that, in the absence of the students, would* ***not*** *be incurred by the provider*. These ***incremental*** costs would include the costs of clinical instructors and administrative and clerical support staff whose function is to coordinate rotations with a nursing school and to schedule clinical rotation for each student nurse. They would ***not,*** however, *include the costs of a charge or floor supervisor nurse who may spend a portion of his or her time supervising student nurses but* ***who, in the absence of the students, would still have to be employed by the provider***. In general, these costs are payroll and related salary costs. *Although some provider-incurred overhead costs* ***directly*** *related to the cost of the students would be allowable*, ***overhead costs incurred by the related organization*** generally would ***not*** be considered allowable. [78]

On January 12, 2001, CMS finalized amended regulations for the payment policy related to costs of approved NAH education programs. The preamble to these regulations stated, in part:

> We clarified in the proposed regulations that the term ''tuition'' includes these additional charges and fees and specified a proposed

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[75] An example of a cafeteria revenue offset can be found on the St. Vincent Medical Center cost report Worksheet A-8, included as Exhibit C-27. On page 43, Line 14 (Cafeteria-employees and guests), the provider has offset $1,664,034, which is noted as "basis B" – which identifies a revenue offset.

[76] 42 C.F.R. § 413.85(d)(2).

[77] The rules were proposed by CMS' predecessor agency, the Health Care Financing Administration ("HCFA").

[78] 57 Fed. Reg. 43659, 43667-43668 (Sept. 22, 1992) (emphasis added).

> formula for determining the net costs to indicate that "total costs" includes only direct and indirect costs incurred by a provider that are *directly attributable* to the operation of an approved educational activity. *These costs do* ***not*** *include usual patient care costs* ***that would be incurred in the absence of the educational activity***, such as the salary costs for nursing supervisors who oversee the floor nurses and student nurses. Moreover, these costs do ***not*** include *costs incurred* ***by a related organization***.[79]
>
> ***
>
> We believe that allowable clinical training costs should be limited to those ***incremental*** *costs that the provider* ***actually incurs in the course of training*** *nursing or allied health students.* If a provider must hire additional staff or increase the salaried hours of existing staff to accomplish the clinical training, the costs of the staff time for providing the training would be considered allowable costs. These staff could include clinical training instructors and administrative and clerical support. However, if the provider merely adds the supervision of students to a floor nurse's list of duties and this is accomplished without the provider incurring additional costs, there is no incremental cost to be claimed.[80]

Clearly, if these costs would exist in the absence of the NAH program, then they are not directly related to the NAH program and, a result, these costs should not be allocated to the NAH program. This definition, on its face, would exclude several the items generally included in the A&G cost center. Using the example of Brockton FY 2014,[81] the Board notes some A&G costs, such as 914 - Lean Program Office Staff, 910 - BHI Managed Care, 953 - BHI Philanthropy,[82] would appear to bear no relationship to the NAH program. Similarly, it is doubtful that the absence of the Brockton's NAH program would have any impact on the costs included in some cost centers such as 936 – BHI Information Services and 950 – BHI Administration Department.[83]

Further, the regulation at 42 C.F.R. § 413.85(d)(2)(ii) states that the total allowable costs "do ***not*** include *patient care costs*, costs incurred ***by a related organization***, or costs that constitute a redistribution of . . . costs that . . . are currently being provided through community support."[84] Some examples of patient care costs included in A&G on the Brockton FY 2014 cost report

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[79] 66 Fed. Reg. 3358, 3367 (Jan. 12, 2001) (emphasis added) (copy at Exhibit C-10).
[80] *Id.* at 3369 (emphasis added).
[81] *See* Exhibit C-27 page 130 for Worksheet A, Line 5, Column 3 for the total A&G cost report expenses and Exhibit C-21 at 1-4 for the provider grouping worksheets. The Board notes that the grouping and the cost report to do reconcile with a minimal rounding variance. The cost report on Worksheet A, Line 5, Column 3 reports $36,356,559 of expenses and the grouping sheet reflects $36,537,568 of expenses.
[82] These are just examples and are not intended to be a complete listing.
[83] These are just examples and are not intended to be a complete listing.
[84] (Emphasis added.)

include cost center 903 – BHI Patient Registration, 935- BHI Case Management, 952- BHI Quality Resources etc. The Board notes, on Exhibit C-27, page 88, that St. Vincent Medical Center, on its 12/31/2015 cost report, has an increase in expenses from Related organization transactions reported on Worksheet A-8, line 12, of $14,136,631. As the record does not include the supporting Worksheet A-8-1, it can only be presumed that some of this related organization expense, which is clearly excluded by regulation from "total allowable costs," is allocated to the A&G cost center, to be allocated as A&G costs. Allocating these costs to the NAH cost centers would be in direct conflict with the regulation.

The Providers make the hyperbolic claim that, "if the tuition that the hospital receives for its NAH activities exceeds the direct costs of those activities, then the NAH cost center would not be allocated any overhead costs at all."[85] Contrary to the Providers' claim, the NAH cost center would receive allocations of all overhead costs, other than A&G costs, in this situation. Moreover, as demonstrated above, many A&G costs are not appropriate for allocation to NAH programs, and it must be considered that the Providers' revenue received as tuition for these programs is a recovery of the programs' costs. Without addressing the effect of such revenue on those costs, a provider could potentially be reimbursed for such costs both by tuition and cost report pass-through reimbursement.

The Providers also contend that the Medicare Contractors' statement that the A&G must be *directly related* to NAH is an attempt "to write cost-finding out of the regulation by limiting the universe of 'directly attributable' costs to only direct costs."[86] The Board disagrees with this contention and finds that the Providers had the option to choose a number of different indirect allocation methodologies, as discussed previously.[87] Further, the Providers could have created componentized A&G cost centers.[88] Using this option, the Providers would be able to differentiate the A&G costs to be allocated to NAH programs from those that should not be allocated to those programs. The Providers had options available to them in the regulations, and the reimbursement manual, which would reflect a more accurate allocation method that would have resulted in a more accurate allocation of A&G cost to their NAH educational programs.

In addition, the Providers claim that, prior to 2017, the cost report permitted post step down adjustments. The Board finds that, nowhere in the cost report instructions does it state that tuition and student fees are to be offset after indirect allocations on Worksheet D, Parts III and IV.[89] In PRM 15-2 § 3613, the discussion of the Worksheet A-8 Adjustments to Expenses, states:

> These adjustments, required under the Medicare principals of reimbursement, are made on the basis of cost or amount received (revenue) *only if* the cost (including direct cost and all applicable

[85] Providers' FPP at 3.
[86] Providers' Consolidated Post-Hearing Brief (hereinafter "Providers' Post Hearing Brief") at 6 (March 1, 2021).
[87] 42 C.F.R. § 413.24
[88] PRM 15-2 § 4013 (Worksheet A instructions for Line 5 (A&G costs)) and PRM 15-2 § 4020 (Worksheets B, Part I and Worksheet B-1 instructions for Column 5 (A&G allocation)).
[89] The instructions for cost reports ending on or after September 30,1996 and beginning before May 1, 2010 (using cost report form CMS-2552-96) are reported at PRM 15-2 § 3600 and the instructions for cost reports beginning on or after May 1, 2010 (using cost report form CMS-2552-10) are reported at PRM 15-2 § 4000.

> overhead) cannot be determined. If the total direct and indirect cost can be determined, enter the cost. Submit with the cost report a copy of any work papers used to compute a cost adjustment.[90]

The instructions list examples of the types of adjustments that would be included on Worksheet A-8. The second example is "those items which constitute recovery of expenses through sales, charges, fee, etc."[91] The Medicare Contractors contend that tuition and students' fee revenue would be a recovery of the costs of the NAH programs and would need to be reflected on Worksheet A-8. Indeed, the CMS-2552-96 cost reporting forms for Worksheet A-8, Line 21, have a hard-coded description of "Nursg school (tuitn, fees, books, etc.)." Similarly, on the CMS-2552-10 forms (for cost reports beginning on/after May 1, 2010), Worksheet A-8, Line 19 has a similar hard-coded description, "Nursing and allied health education (tuition, fees, books, etc.)." The fact that CMS assigned this description (in both the 1996 and the 2010 iterations of the CMS-2552 forms) to a specific line on Worksheet A-8 makes it clear that the offset of NAH program tuition on Worksheet A-8 was intended by CMS. The Board notes that CMS made it abundantly clear in Transmittal 12, dated November 17, 2017, which revised and clarified PRM 15-2 § 4022 with the following instruction that post step-down adjustments related to NAH costs on Worksheet B-2 are not permissible:

> NOTE: Do not use this worksheet to reduce the total allowable costs that are directly related to the NAHE programs by the revenue received from tuition and student fees. Use Worksheet A-8 to offset NAHE program costs by tuition and student fees (42 CFR 413.85(d)(2)(i)). Do not use a post step-down adjustment.[92]

What CMS has prohibited, the Providers have tried to do by using a different approach, namely offsetting tuition and student fee revenue through Worksheet D, Parts III and IV, rather than through the Worksheet B-2 Post Step Down process on B Part I, in Column 25. The Providers' approach ignores the PRM 15-2 § 4022 instruction to use Worksheet A-8 when offsetting these revenues. Based on the above analysis, the Board finds Transmittal 12's revisions to PRM 15-2 § 4022 to be clarification of the *preexisting* policy.

In summary, the Board finds that the cost report instructions are clear that the tuition and student fees are to be offset on Worksheet A-8. Nowhere in the cost report instructions does it suggest that the revenue offset should occur after the indirect allocation of overhead expense on Worksheet B-2 (which is clearly prohibited by Transmittal 12) or on Worksheet D, Parts III and IV. In addition, the Board finds the ***only*** A&G costs that may be allocated to the NAH programs are those ***directly*** *related* to the NAH programs. Further, those costs may ***neither*** be related to patient care, be related party costs, *nor* constitute a redistribution of costs that have been or are currently being provided through the community. Finally, the Board finds there were several allocation options available, in the regulations and reimbursement manuals, which the Providers could have pursued to more accurately allocate those specific indirect A&G overhead costs applicable to their NAH

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[90] (Emphasis added.)
[91] PRM 15-2 § 3613.
[92] Copy included at Exhibit C-19.

programs. However, the Providers failed to identify those options and then seek and obtain approval of the Medicare Contractor for an alternative allocation methodology consistent with PRM 15-1 § 2313 and 42 C.F.R. § 413.24(d)(2)-(3).

## DECISION

After considering Medicare law and regulations, the arguments presented, and the evidence admitted, the Board finds that it was appropriate for the Medicare Contractors to offset tuition revenue for NAH programs on Worksheet A-8 for the fiscal years at issue.

## BOARD MEMBERS:

Clayton J. Nix, Esq.
Gregory H. Ziegler, C.P.A.
Robert A. Evarts, Esq.
Kevin D. Smith, C.P.A.
Ratina Kelly, C.P.A.

**FOR THE BOARD:**

9/26/2022

X Clayton J. Nix

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

**ATTACHMENT A**

**Listing of Cases**

| | |
|---|---|
| 18-0890 | St. Vincent Mercy Medical Center (36-0112) FYE 12/31/2009 |
| 18-0896 | St. Vincent Mercy Medical Center (36-0112) FYE 12/31/2014 |
| 18-0897 | St. Vincent Mercy Medical Center (36-0112) FYE 12/31/2015 |
| 18-0898 | St. Vincent Mercy Medical Center (36-0112) FYE 12/31/2010 |
| 20-0275G | King & Spalding CY 2012-2015 Nursing & Allied Health Tuition Group |
| 20-0621G | King & Spalding CY 2016 Nursing & Allied Health Tuition Group |

# ATTACHMENT B

## Schedule of Providers

**Case Number:** 20-0275G
**Case Name:** King & Spalding CY 2012-2015 Nursing & Allied Health Tuition Group
**Appealed Period:** CY
**Period End:** 12/31/2012

| Organization # | Organization Name | Cost Reporting Period Affected | Addnl. Cost Reporting Period Affected | MAC Code | Determination Type | Final Determination Date | Issue Submission Date | # of Days | Audit Adjustment Number | Controversy Amount | Provider Status | Fiscal Year End | Provider Source | Transfer From - Case Number | Date GCP Added/ Transferred |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 33-0169 | Mount Sinai Beth Israel (33-0169) | | | J-K | Notice of Program Reimbursement (NPR) | 05/07/2019 | 11/04/2019 | 181 | N/A | 163947 | Active | 12/31/2012 | Direct Add | | 11/04/2019 |
| 33-0169 | Mount Sinai Beth Israel (33-0169) | | | J-K | Notice of Program Reimbursement (NPR) | 08/19/2019 | 11/04/2019 | 77 | n/a | 202560 | Active | 12/31/2013 | Direct Add | | 11/04/2019 |
| 22-0052 | Signature Healthcare Brockton Hospital (22-0052) | | | J-K | Revised NPR | 10/02/2018 | 03/28/2019 | 177 | 1, 2, 3 | 1006830 | Active | 09/30/2014 | Transferred | 19-1561 | 11/04/2019 |
| 22-0052 | Signature Healthcare Brockton Hospital (22-0052) | | | J-K | Notice of Program Reimbursement (NPR) | 10/02/2018 | 03/28/2019 | 177 | 28, 32, 45, 48 | 513407 | Active | 09/30/2015 | Transferred | 19-1558 | 11/04/2019 |

# Schedule of Providers

**Case Number:** 20-0621G
**Case Name:** King & Spalding CY 2016 Nursing & Allied Health Tuition Group
**Appealed Period:** CY
**Period End:** 12/31/2016

| Organization # | Organization Name | Cost Reporting Period Affected | Addnl. Cost Reporting Period Affected | MAC Code | Determination Type | Final Determination Date | Issue Submission Date | # of Days | Audit Adjustment Number | Controversy Amount | Provider Status | Fiscal Year End | Provider Source | Transfer From - Case Number | Date GCP Added/ Transferred |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 28-0003 | Bryan Medical Center (28-0003) | | | J-5 | Notice of Program Reimbursement (NPR) | 07/17/2019 | 01/13/2020 | 180 | 38 | 297014 | Active | 12/31/2016 | Direct Add | | 01/13/2020 |
| 28-0013 | The Nebraska Medical Center (28-0013) | | | J-5 | Notice of Program Reimbursement (NPR) | 07/19/2019 | 01/13/2020 | 178 | NA | 1369025 | Active | 06/30/2016 | Direct Add | | 01/13/2020 |