PROVIDER REIMBURSEMENT REVIEW BOARD HEARING DECISION

2000-D9

PROVIDER - AllCare Home Health,Inc
Denver, Colorado

Provider No. 06-7201

vs.

INTERMEDIARY -
Blue Cross and Blue Shield Association/Wellmark Blue Cross and Blue Shield

DATE OF HEARING-
January 28, 1999

Cost Reporting Period Ended -
May 31, 1996

CASE NO. 98-1081

INDEX

ISSUE:[1]

Were the Intermediary's adjustments to owners' compensation proper?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

AllCare Home Health Inc. ("Provider") is a proprietary, for-profit, home health agency located in Denver, Colorado. For the fiscal year ended May 31, 1996, the Provider claimed compensation for the services of two owners who held the positions of Administrator/Chief Executive Officer ("CEO") and Chief Financial Officer ("CFO"). Upon audit of the Provider's Medicare cost report, Blue Cross and Blue Shield Association/Wellmark Blue Cross and Blue Shield ("Intermediary") issued a Notice of Program Reimbursement which included adjustments to these claimed costs. The following is a summary of the elements of compensation, and the amounts allowed and disallowed by the Intermediary for the positions in dispute (Rounded Amounts):

	CEO	CFO	TOTAL
Base Salary	$ 90,000	$66,000	$156,000
Fringe Benefits	4,000	4,000	8,000
Bonus	33,000	27,000	60,000
Total Compensation	$127,000	$97,000	$224,000
Allowed Amounts	82,500	67,000	149,500
Disallowed Amounts	$ 44,500	$30,000	$ 74,500

The Intermediary based its adjustments on the application of the Michigan Study, which was updated to adjust for the compensation survey data compiled in 1979. The Provider filed a timely appeal with the Provider Reimbursement Review Board ("Board") pursuant to 42 C.F.R. §§405.1835-.1841, and has met the jurisdictional requirements of those regulations. The Medicare reimbursement effect is approximately $69,000.

The Provider was represented by Charles F. MacKelvie, Esquire, of MacKelvie and Associates. The Intermediary's representative was Bernard M. Talbert, Esquire, of the Blue Cross and Blue Shield Association.

[1] All other issues previously appealed by the Provider have been administratively resolved, withdrawn, or consolidated with the remaining issue.

PROVIDER'S CONTENTIONS:

The Provider contends that the Michigan Study used by the Intermediary to support the compensation adjustments violates the General Accounting Office's ("GAO") general auditing standards that apply to the Health Care Financing Administration ("HCFA") and its fiscal intermediaries. In support of this contention, the Provider offered a former HCFA official as an expert witness[2] who testified that the GAO's general auditing standards require all data used in a cost report audit to be relevant, competent, and sufficient evidence of the audit's validity. Since the sample size of the Michigan Study was insufficient, it does not meet GAO's auditing standards. Further, the sample size also violates the requirements of the Office of Management and Budget because it must have a minimum response rate of 75 percent or contain a statement in the audit that the sample size was insufficient. Other violations of the GAO's auditing standards include the Intermediary's failure to preserve and maintain the underlying documentation and workpapers of the Michigan Study which have been lost or destroyed.

The Provider further contends that the Michigan Study does not meet the requirements in Chapter 9 of the Provider Reimbursement Manual ("HCFA pub. 15-1") because it does not compare home health agencies by size in the same geographical region. In addition, the Michigan Study is based on outpatient physical therapy ("OPT") services which are not relevant to home health services. The Provider further argues that changes in the Medicare program and health care delivery since 1979 when the Michigan Study was compiled renders its application inept to determine a reasonable range of owner's compensation. Merely trending forward the Michigan Study's data for inflation fails to accurately capture the changes that have occurred in health care delivery and reimbursement.

The Provider contends that the Intermediary's methodology also violates the requirements set forth under 42 C.F.R. §413.102 and HCFA Pub. 15-1 §904. These provisions require the Intermediary to determine the reasonableness of owner's compensation by comparing it to the compensation paid by other comparable institutions that provide comparable services. The Intermediary's reliance on data contained in the Michigan Study to perform its comparisons fails to take the Provider's geographical location into account. In support of this contention, the Provider cites various decisions rendered by the Board on this matter. In the decision rendered for El Paso Nurses Unlimited, Inc. v. Blue Cross and Blue Shield Association/Blue Cross and Blue Shield of Texas, PRRB Dec. No. 89-D2, November 3, 1988, Medicare & Medicaid Guide (CCH) ¶37,505, the Board held that "the Intermediary's use of the Denver Regional Office's survey [to adjust a Texas provider's salaries] is inappropriate because the Provider is from a different area." Other decisions cited by the Provider include; Stat Home Health Care, Inc. v. Blue Cross and Blue Shield Association/Blue Cross of California, PRRB Dec. No. 96-D7, January 30, 1996, Medicare & Medicaid Guide (CCH) ¶44,011, wherein the Board found that the intermediary's adjustment to owner's compensation could not be upheld because the data the intermediary relied on was "outdated, inappropriate, and inadequate;" and, Condado Home Care Program v. Cooperativa De Seguros De Vida, PRRB Dec. No. 97-D52, April 24, 1997, Medicare &

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[2] Tr. at 92-137.

Medicaid Guide (CCH) ¶45,197, where the Board found that "the Intermediary did not properly adjust the Provider's owner's compensation because it did not compare the owner's compensation with that of other like providers as required by Medicare regulations.

The Provider contends that the Intermediary's adjustments are also improper because the Michigan Study is statistically invalid, outdated, and an inappropriate method for determining reasonable compensation for home health agencies since it was designed for OPT clinics. The Provider argues that Blue Cross of Michigan, the developer of the OPT Study, recognized the survey's limitations and that the survey was never contemplated to be used to evaluate home health agency compensation. The Provider quotes a Senior Appeals Analyst for Blue Cross of Michigan as stating:

> [p]lease note with caution that the guidelines and attached questionnaires were designed using Michigan survey data and salary ranges were updated using Michigan cost of living indices. I strongly advise against applying these guidelines without modification to [Iowa] OPTs . . . . The guidelines must be applied with care and reason and the resulting figure cannot be blindly accepted, but must be judged and perhaps modified by common sense.

Letter to Blue Cross of Iowa, dated November 5, 1981. See Provider's Exhibit 10.

Further, the Provider argues that the study is outdated since it was developed in 1979, 17 years prior to the cost reporting period at issue, and was not updated except for the application of a yearly inflation factor. The Provider asserts that such an inflation update is only valid in the short term until new survey data can be obtained.

The Provider further contends that the Intermediary's adjustments are improper because the Intermediary failed to meet its burden of proof that the owners' compensation at issue was "substantially out of line" in accordance with 42 C.F.R. §413.9(c)(2) which states in part:

> The provision in Medicare for payment of reasonable cost of services is intended to meet the actual costs, however widely they may vary from one institution to another. This is subject to a limitation if a particular institution's costs are found to be substantially out of line with other institutions in the same area that are similar in size, scope of services, utilization, and other relevant factors.

42 C.F.R. §413.9(c)(2).

The Provider cites various Board and court decisions holding that an adjustment must be reversed when an intermediary fails to meet its burden of proving that a cost is "substantially out of line." See Memorial Hospital/Adair County Health Center, Inc. v. Bowen, 639 F. Supp. 434 (D.D.C. 1986),

aff'd 829 F.2d 111 (D.C. Cir. 1987); Home Health Care, Inc. V. Heckler, 717 F. 2d 587 (D.C. Cir. 1983); Alexander's Home Health Agency v. Blue Cross and Blue Shield Association/Blue Cross and Blue Shield of Mississippi, PRRB Dec. No. 88-D30, September 2, 1988, Medicare and Medicaid Guide (CCH) ¶ 37,439, aff'd HCFA Administrator, October 31, 1988, Medicare and Medicaid Guide (CCH) ¶ 37,504; and Holy Cross Hospital v. Blue Cross and Blue Shield Association/New Mexico Blue Cross and Blue Shield, PRRB Dec No. 92-D14, February 14, 1992, Medicare and Medicaid Guide (CCH) ¶ 40,066, aff'd HCFA Administrator, April 13, 1992, Medicare and Medicaid Guide (CCH) ¶ 40,421.

The Provider also argues that the Home Care Salary and Benefits Report 1995-1996 (a/k/a the "Zabka Study"), as proffered by the Intermediary to corroborate its compensation adjustments, is incomplete and fundamentally flawed. The Zabka Study is prepared annually by using questionnaires sent out to approximately 18,000 Medicare and non-Medicare home care agencies and hospices throughout the United States. In 1995-1996, the surveyors received 1,483 unaudited responses, a response rate of only 14 percent. At the hearing before the Board, the Provider's outside consultant testified that the Zabka Study is flawed because it intentionally disregards the top 25 percent and bottom 25 percent of the salary responses prior to formulating its compensation ranges. Thus, the methodology applied has the effect of skewing all agencies to the middle of the reported compensation.[3] The witness further testified that only three agencies in the Denver area responded to the request for data on the CEO/Administrator compensation amount.[4]

Despite the problems cited with the Zabka Study, the Provider's witness testified that the owners' compensation claimed by the Provider was reasonable if the Intermediary had not intentionally excluded bonuses from the total compensation package. If the data from the Zabka Study is properly interpreted, and the salary of the Provider's executives are adjusted for bonuses and non-statutory fringe benefits, the total compensation claimed by the Provider was reasonable under the Zabka Study.[5] This witness believed it was important for the Intermediary not to pick and choose among the various categories available to reward home health executives in determining a reasonable level of compensation, but to consider all of the factors as a whole to arrive at a total reasonable amount.[6]

In contrast to the scant evidence offered by the Intermediary to support its adjustments, the Provider asserts that it presented timely and geographically relevant data from three credible and reliable sources supporting its position that the amount of owners' compensation claimed was reasonable. The first

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[3] Tr. at 143.

[4] Tr. at 146.

[5] Tr. at 155.

[6] Tr. at 151.

source cited by the Provider is a 1974 survey of the Denver Region [Medicare & Medicaid Guide (CCH) ¶5623.75] conducted by the Bureau of Health Insurance, the predecessor to HCFA.[7] At the hearing, the Provider's witness presented testimony showing that the Denver Survey properly updated to 1996 would yield a maximum salary of $112,000. By adding additional amounts for benefits and a bonus, a CEO/Administrator could be entitled to $156,000 in total compensation under the Denver Study. With respect to the CFO position, the Provider notes that intermediaries often allow a second in command at a home health agency 75 percent of the amount allowed for the CEO/Administrator. Applying this formula, a CFO in the Denver area could be entitled to $120,000 in total compensation. Accordingly, the compensation amounts claimed by the Provider for these two positions would be reasonable under the updated Denver Survey.[8]

The second source of data presented by the Provider was cost report data for similar fiscal years on compensation from home health agencies in Colorado that were compiled by a commercial vendor, Health Financial Systems ("HFS").[9] A review of the HFS' listed data demonstrates that the compensation claimed by the Provider for its CEO/Administrator and CFO are approximately in the mid-range of the listed home health agencies. The Provider believes the HFS' data are meaningful because they are timely, and are the only material presented by either party that employ a comprehensive and statistically valid sample of 1996 costs as a way of comparing what home health agencies were paying their key executive in the Denver area. Moreover, the HFS' data comply with the regulations and program instructions by providing comparative compensation from other similar agencies, and conclusively show that the Provider's compensation claims were reasonable and not substantially out of line with comparable institutions.

Finally, the Provider submitted a study of its claimed executive compensation performed by Dr. Randall Dunham of the University of Wisconsin.[10] This study carefully compares home health jobs to hospital positions with similar responsibilities to determine a reasonable range of compensation for the home health industry. Using the Dunham methodology, the Compensation Evaluation Study for the Provider produced the following reasonable pay ranges:

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[7] Provider Exhibit P-29.

[8] Tr. at 161-163.

[9] Provider Exhibits P-22-P-25.

[10] Provider Exhibit P-12.

Reasonable Cash Compensation for AllCare Jobs for 1996

Job	Minimum	Midpoint	Maximum
President/Chief Executive Officer	$82,320.31	$102,900.39	$123,480.46
Chief Financial Officer/Information Officer	$44,958.19	$ 56,197.74	$ 67,437.29

Reasonable Total Compensation for AllCare Jobs for 1996

Job	Minimum	Midpoint	Maximum
President/Chief Executive Officer	$107,016.40	$133,770.50	$160,524.60
Chief Financial Officer/Chief Information Officer	$ 58,445.65	$ 73,057.06	$ 87,668.47

The Provider notes that Dr. Randall Dunham is widely respected in the field of executive compensation, and that the Board and fiscal intermediaries have relied on his methodology and testimony in numerous cases for evaluating reasonable compensation appeals.

In summary, the Provider argues that the Intermediary has failed to support its adjustments, and that the application of the Michigan Study and Zabka Study does not comply with Medicare law, regulations and general instruction, and also violate government auditing standards. In contrast, the Provider has proven by a preponderance of evidence that the compensation amounts paid to its key executives were reasonable and not substantially out of line when compared to similar agencies in its geographic area.

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that its adjustments to owners' compensation were made to reduce the claimed amounts to a reasonable level in accordance 42 C.F.R. §§ 413.9 and 413.102 and Chapter 9 of HCFA Pub 15-1. The regulation at 42 C.F.R. §413.9(c)(2) states:

> The costs of providers' services vary from one provider to another and the variations generally reflect differences in scope of services and intensity of care. The provision in Medicare for payment of reasonable

> cost of services is intended to meet the actual costs, however widely they may vary from one institution to another. This is subject to a limitation if a particular institution's costs are found to be substantially out of line with other institutions in the same area that are similar in size, scope of services, utilization, and other relevant factors.

42 C.F.R. § 413.9(c)(2).

The regulatory provisions at 42 C.F.R. §413.102 specifically address compensation to owners and define compensation and reasonableness as follows:

> (1) Compensation. Compensation means the total benefit received by the owner for services he furnishes to the institution.
>
> (2) Reasonableness. Reasonableness requires that the compensation allowance--
>
> (i) Be such an amount as would ordinarily be paid for comparable services by comparable institutions; and
>
> (ii) Depend upon the facts and circumstances of each case.

42 C.F.R. §413.102 (b)(1) and (2).

The Intermediary asserts that the employees at issue are subject to the regulations and manual instructions concerning owner's compensation, and that the determination of reasonable compensation by "other appropriate means" is allowed under the governing provisions as follows:

> Ordinarily compensation paid to proprietors is a distribution of profit. However, if a proprietor furnishes necessary services for the institution . . . reasonable compensation for these services is an allowable cost. If services are furnished on less than a full time basis, the allowable compensation should reflect an amount proportionate to a full-time basis. Reasonableness 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.

42 C.F.R. § 413.102(c)(2) (emphasis added).

The manual instructions in HCFA Pub. 15-1 §902.3 define reasonable compensation as the fair market value of services rendered by an owner, which is determined by supply and demand factors in the open

market. Since owners have the ability to establish their own compensation levels, there was no open market for the Provider's CEO and CFO positions in the instant case. Accordingly, "other appropriate means" were used in determining reasonable owners' compensation.

Consistent with the regulatory and manual provisions, the Intermediary resorted to an alternative method and used the Michigan Study to determine reasonable compensation for the Provider's CEO and CFO positions. The Michigan Study includes salaries and fringe benefits from 16 visiting nurse associations and home health agencies located in the state of Michigan. Annual compensation ranges have been developed for four key administrative positions, and a point system is used to place an employee within the salary range based on relative weights given for such factors as education, experience, volume, job duties and geographic location. Since the Michigan Study includes compensation ranges for years 1975 through 1980, HCFA adjustment factors were applied to adjust for changes in fair market values and economic conditions, and updated to the Provider's fiscal year in contention.

Based on the application of the Michigan Study, the Intermediary determined a reasonable compensation amount of $82,500 for the Provider's CEO position and $66,688 for the Provider's CFO position.[11] In support of its application of the Michigan Study, the Intermediary cites two decisions where the HCFA Administrator reversed the Boards decisions. In High Country Home Health Care, Inc. v. IASD Health Services Corporation, PRRB Dec. No. 98-D33, March 18, 1998, Medicare and Medicaid Guide (CCH) ¶46,172, rev'd, HCFA Administrator, May 22, 1998 Medicare and Medicaid Guide (CCH) ¶80,057 ("High Country"), the Administrator found that the Michigan Study is an appropriate means to determine the reasonableness of owner's compensation as provided by the regulations. The Intermediary's position is also supported by the decision rendered in Call-A-Nurse, Inc., v. Blue Cross and Blue Shield Association, et. al., PRRB Dec. No. 98-D50, May 20, 1998, Medicare and Medicaid Guide (CCH) ¶46,331, rev'd, HCFA Administrator, July 27, 1998, Medicare and Medicaid Guide (CCH) ¶80,060 ("Call-A-Nurse"). In that case, the Administrator again found that the Michigan Study was an appropriate means of determining reasonable owner's compensation.

In support of its position, the Intermediary corroborated the results of the Michigan Study by comparing its reasonable compensation determinations with the Home Care Salary & Benefits Report 1995-1996 ("Zabka Study").[12] This national survey of home health agency salaries identifies the low, median and high salaries for the Executive Director and Financial Director of a for-profit home health agency in the regional area that includes the city of Denver as follows:

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[11] See Intermediary Exhibit I-1.

[12] See Intermediary Exhibit I-10.

	Low	Median	High
Executive Director	$46,462	$61,636	$72,930
Financial Director	$46,500	$55,743	$65,000

Applying a nonstatutory fringe benefit rate of 20.64% to the high salary amounts for each position, the Intermediary determined that the adjusted compensation for the CEO and CFO positions would be $87,983 and $78,416, respectively. The Intermediary notes that the Zabka Study also identifies a high salary amount for the city of Denver of $80,789 for the Executive Director and $56,044 for the Financial Director. It is the Intermediary's position that it would be inappropriate to allow the high side of the salary range as reasonable compensation since the Provider has not supported that the complexity of its operations or the responsibilities of its executive employees would warrant such a high compensation level. Accordingly, the Intermediary concludes that the results of the Michigan Study are consistent with other national healthcare compensation surveys, and that it has fulfilled its responsibility in determining reasonableness.

With respect to the Provider's reliance on the analysis of executive compensation performed by Dr. Randall Dunham, the Intermediary again refers to the HCFA Administrator's decision in Call-A-Nurse. In that decision, the Administrator found that the "Dunham Study" compared home health agency positions with "similar responsibilities" to positions in the hospital industry. The Administrator concluded that "hospitals are less comparable institutions performing comparable services than the OPT facilities used in the Michigan Study." Accordingly, the Intermediary cannot place any reliance on the results of the "Dunham Study" without supporting documentation. In the instant case, the Intermediary further notes that, if the cash compensation amounts under the Michigan Study are compared to the midpoint amounts determined by Dr. Dunham for measuring reasonable cash compensation, the adjustment for the CFO position is fully supported. With respect to the CEO position, the amount the Provider is seeking is significantly higher than the cash compensation midpoint determined by Dr. Dunham.

In its post-hearing submission, the Intermediary points out that the "bonus" amounts paid by the Provider to its CEO and CFO need to be evaluated carefully since the bonuses represent over 75 percent of the amount in dispute. While bonuses can be properly labeled as compensation, the arbitrary method used by the Provider to calculate these amounts supports an adjustment amount that effectively eliminates the bonuses paid to the CEO and CFO. Rather than determining the bonus amount under an organized incentive program, the amount identified by the Provider represents the spread between its actual costs and the cost limits established under the Medicare program. For the period in contention, this amount was $153,000. The owners' bonus amount of $60,000 represents the amount left over after payments for a variety of employee related perquisites to "rank and file" employees. It is the Intermediary's position that the Medicare cost limits do not create payment entitlement. Payments in the nature of a bonus should emanate from a well-defined incentive plan with clear standards, which was not in place at the appealing Provider.

CITATION OF LAW, REGULATIONS AND PROGRAM INSTRUCTIONS:

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

§1395x(v)(1)(A)	-	Reasonable Cost

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

§§405.1835-.1841	-	Board Jurisdiction
§413.9 et seq.	-	Cost Related to Patient Care
§413.102 et seq.	-	Compensation of Owners

3. Programs Instructions - Providers Reimbursement Manual, Part I (HCFA Pub. 15-1):

Chapter 9 et seq.	-	Compensation of Owners

4. Case Law:

Memorial Hospital/Adair County Home Center, Inc. v. Bowen, 639 F. Supp 434 (D.D.C. 1986), aff'd 829 F. 2d 111 (D.C. Cir. 1987).

Home Health Care, Inc. v. Heckler, 717 F. 2d 587 (D.C. Cir. 1983).

High Country Home Health, Inc. v. Shalala, No. 98-CV- 184-J (D.Wy. March 25, 1999).

Call-A-Nurse v. Shalala, 59 F. Supp. 2d 938 (E.D.Mo. 1999).

Alexander's Home Health Agency v. Blue Cross and Blue Shield Association/Blue Cross and Blue Shield of Mississippi, PRRB Dec. No. 88-D30, September 2, 1998, Medicare and Medicaid Guide (CCH) ¶37,439, aff'd HCFA Administrator, October 31, 1988, Medicare and Medicaid Guide (CCH) ¶37,504.

El Paso Nurses Unlimited, Inc. v. Blue Cross and Blue Shield Association/Blue Cross and Blue Shield of Texas, PRRB Case No. 89-D2, November 3, 1988, Medicare and Medicaid Guide (CCH) ¶37,505, declined rev. HCFA Administrator, December 6, 1988.

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

Stat Home Health Care, Inc. v. Blue Cross and Blue Shield Association/Blue Cross of California, PRRB Dec No. 96-D7, January 30, 1996, Medicare and Medicaid Guide (CCH) ¶ 44011, declined rev. HCFA Administrator, March 15, 1996.

Condado Home Care Program (Santurce, Puerto Rico) v. Cooperativa De Seguros De Vida, PRRB Dec. No. 97-D52, April 24, 1997, Medicare & Medicaid Guide (CCH) ¶45,197, declined rev. HCFA Administrator, June 13, 1997.

High Country Home Health Care, Inc. v. IASD Health Services Corporation, PRRB Dec. No. 98-D33, March 18, 1998, Medicare and Medicaid Guide (CCH) ¶46,172, rev'd HCFA Administrator, May 22, 1998, Medicare and Medicaid Guide (CCH) ¶80,057.

Call-A-Nurse, Inc. v. Blue Cross and Blue Shield Association, et. al., PRRB Dec. No. 98-D50, May 20, 1998, Medicare and Medicaid Guide (CCH) ¶46,331, rev'd, HCFA Administrator, July 27, 1998, Medicare and Medicaid Guide (CCH) ¶80,060.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board, after consideration of the facts, parties contentions, evidence presented, testimony elicited at the hearing and post-hearing briefs, finds and concludes as follows:

Based on the evidence presented, the total amount of owners compensation claimed by the Provider for its CEO and CFO positions consisted of the following components:

	CEO	CFO	TOTAL
Base Salary	$90,000	$66,000	$156,000
Fringe Benefits	4,000	4,000	8,000
Salary & Benefits	$94,000	$70,000	$164,000
Bonus	33,000	27,000	60,000
Total Compensation	$127,000	$97,000	$224,000

With respect to the claimed bonus payments, the Board finds no evidence in the record of this case to support the existence of a formalized incentive program that would validate the sizeable bonus payments claimed by the owners for services rendered in their respective management positions. Rather, the only evidential presentation consists of the CEO's testimony at the hearing in response to questions put forth by the Intermediary's counsel as to how the bonus amounts were determined (Tr. at 62-71). The Board believes the following excerpts from the CEO's testimony clearly reflect the character of the bonus payments claimed by the Provider:

By Mr. Talbert:

Q. When you referred to looking at the agency's profit to determine additional compensation over the base salary, what did you mean?

A. I don't mean profit. I mean, if you have -- if you're still going to be well beneath the caps and you realize that you have some key employees that you didn't give a raise to, how you compensate different people, including ourselves. That's what I'm referring to.

Q. So you used the cap, the cost caps, the difference between your costs as they're developed on a periodic basic basis, including the base salary, and the cost caps to determine some type of additional amounts to use as raises or bonuses? Is that correct?

A. Not for the salary purpose. But, essentially, we know -- we don't know from day one where we're going to be. And so we've already allocated, even from my salary, roughly what I should be making. So rather than --

Q. When you say roughly what you should be making, what number are you referring to? The $72,000?

A. Based on the previous year.

Q. Okay.

A. So, rather than changing the payroll and getting into a problem later, we make the adjustments either once a year or twice a year.

Q. Your bonus was paid, if I understand the testimony, or the presentation of your case, the bonus that you and Mrs. Bhasin received came out of a $153,000 bonus accrual that took place at the end of the fiscal period. Is that correct?

A. That's correct.

Q. How is that $153,000 determined in total?

A. Essentially, it was a joint discussion between Mr. Baird, Mrs. Bhasin and myself.

Q. But, is there some written agency policy that describes the bonus program and how it's to be computed?

A. I'm not sure.

Tr. at 62-64.

By Mr. Talbert:

Q. You said that the $153,000 was established in a joint discussion between you and Mrs. Bhasin and Mr. Baird. And that was right at the end of the fiscal period. When was that decision made on the calendar?

A. Okay. First of all, we keep looking at the numbers not just at the last month. We look at it on a monthly basis. We just don't make the adjustments until the time is right. You cannot just start making adjustments even for bonus. We know we have a fairly good idea as to this year where its heading. So it's not a question that we fiscally manage at the eleventh month. It doesn't happen that way. So we have a fairly good idea where we need to be under the caps. And if this is the income that we are -- that we have, that this is the adjustment that is going to be at a certain time of the year.

Q. So was the $153,000 determined when it was determined based upon some type of financial analysis?

A. That's correct.

Q. And we don't have a record of exactly what the mechanics or the arithmetic of doing that is?

A. Unless you want Mark -- Mr. Baird here.

Q. That's up to Mr. MacKelvie.

A. I think, since the banks work closely with us, obviously, we

look at all the financials very carefully. So at what time of the year we disburse the funds is based on what our receivables are.

Q. You got ahead of me. You got ahead of me. Okay, the $153,000 was determined to be an appropriate additional amount to reward all the employees, yourself included, for what happened in 1996. I mean, is that a fair capsule of the decision process?

A. That's correct.

Tr. at 68-70.

The Board finds the above testimony provides substantial evidence that the bonus payments claimed as owners' compensation for the CEO and CFO resulted from the Provider's year-end analysis of its actual reportable costs versus the maximum amount of program reimbursement obtainable without exceeding the Medicare cost limits. Accordingly, it is the Board's conclusion that such payments are analogous to the payment of a return on equity capital to the owners of the home health agency, and should not be treated as allowable compensation in the determination of the Provider's reasonable cost. Under the provisions of 42 C.F.R. §413.102(c)(2) and HCFA Pub. 15-1 §902.2, the bonus payments of $60,000 claimed by the Provider for its CEO and CFO are not compensation amounts for purposes of determining the reasonable level of reimbursement for the owners' employee services.

Regarding the remaining salary and benefits of $94,000 for the CEO and $70,000 for the CFO, the Board finds that the Intermediary's reasonable compensation determinations were not appropriate and cannot be supported under the reasonable compensation provisions of 42 C.F.R. §413.102 and HCFA Pub. 15-1 §900ff. The regulation at 42 C.F.R. § 413.102 explains that the reasonableness of compensation paid to the proprietor of a health care organization may be determined by comparing it to the compensation paid for like services performed in comparable institutions or "by other appropriate means." The program instructions at HCFA Pub. 15-1 §904.1 provide factors which are to be considered in determining the comparability of institutions. These factors include but are not limited to the size of the institution, its classification by type and range of services provided, personnel employed, and geographical location.

In determining an appropriate amount of reasonable compensation, the Board finds that it must assess the quality of the salary data in the record and rely on the best evidence presented. In the instant case, the parties have presented five surveys or evaluations which the Board considered in reaching its decision on reasonable owners' compensation. In accordance with the broad language of the regulatory and manual provisions, the Intermediary applied the data and methodology set forth under the Michigan Study in making its reasonable compensation determinations. It is the Board's finding that the salary range data generated from the outdated Michigan Study produced results that are not

representative of the Provider's organization, and cannot serve as the basis for the disallowances devised by the Intermediary. The Michigan Study was designed for OPT owner/administrators, and is based on data obtained in 1979 from 16 facilities located in the Michigan area. Given these factors, the Board finds that there is no assurance that the compensation data contained in the Michigan Study is representative of the compensation levels paid by contemporary home health organizations in the Provider's geographical location.

As to the Intermediary's employment of the Zabka Study to corroborate its determinations, the Board finds the evidence placed in the record for the Zabka Study is incomplete, and cannot be relied upon to support the Intermediary's application of the Michigan Study. While testimony was presented as to the make up of the Zebka Study and the manner in which bonuses and fringe benefits should be calculated in determining reasonable compensation, the Board finds the testimonial statements to be inconsistent and without foundation. In the absence of reliable and supportable documentary evidence as to how the Zabka Study was conducted and the methodology employed for the application of the data, the Board is unclear as to its application in this case.

In support of its position, the Provider presented compensation data which it compiled from the Denver Survey, HFS' data and the Compensation Evaluation Study performed by Dr. Randall Dunham. With respect to the Denver Survey, the Provider used the high salary figure developed from a 1974 survey, and trended this amount forward to 1996 using the consumer price index ("CPI"). The Board finds the use of the outdated Denver Survey to be unreliable in the absence of supportable documentation. In particular, the Board notes that the Provider failed to provide any supporting documentation for either the CPI data applied to the 1974 salary amount or the computation of the additional bonus and fringe benefit amounts used in determining total compensation for the CEO and CFO positions. With respect to HFS' data, the Board finds its application equally unreliable in that the data reflects unaudited salary amounts that have not been evaluated to ascertain the types of position being reported or the components included in the total compensation amounts. Accordingly, the validity of the Denver Survey and HFS' data cannot be substantiated, and should not be utilized in determining reasonable compensation in this case.

The Board finds that the best evidence for evaluating the reasonableness of owners' compensation in the instant case is contained in the Compensation Evaluation Study that was specifically performed for the Provider by Dr. Randall Dunham. Although the Dunham Study is based on hospital data, the evaluation explicitly compares home health administrative jobs to hospital positions with similar responsibilities to determine a reasonable range of compensation for the home health industry. By focusing on the level of responsibilities as well as other criteria in determining reasonable compensation levels for the Provider's CEO and CFO positions, it is the Board's conclusion that the Dunham compensation evaluation applies a credible and reliable methodology that comprehensively determined reasonable owners' compensation in this case. Table 5 of the Compensation Evaluation

Studyperformed for the Provider for 1996 reflects the following reasonable total compensation data:[13]

Job	Minimum	Midpoint	Maximum
President/CEO	$107,016.40	$133,770.50	$160,524.60
CFO/CIO	58,445.65	73,057.06	87,668.47

Since the salary and benefits amounts claimed by the Provider in the instant case are $94,000 and $70,000 for the CEO and CFO, respectively, these amounts fall below the comparable midpoint compensation levels established under the Compensation Evaluation Study prepared for the Provider by Dr. Dunham. Accordingly, it is the Boards's conclusion that the owners' compensation amounts claimed by the Provider for salary and benefits are reasonable amounts that are fully allowable in determining Medicare reimbursement for the fiscal year in contention.

The Board is aware that the Intermediary cited the HCFA Administrator's decisions in High Country and Call-A-Nurse in support of its application of the Michigan Study. However, the Board notes that both of these decisions were reversed by the following district court decisions:

> High Country Home Health Inc. v. Shalala, No. 98-CV-184-J (D.Wy. March 25, 1999).
>
> Call-A-Nurse v. Shalala, 59 F. Supp. 2d. 938 (E.D. Mo. 1999).

In the Call-A-Nurse decision, the district court stated the following:

> > Upon review of the record, the Court believes that reliance in this case upon the Michigan Survey was arbitrary because the OPT clinics studied in that survey were not comparable to Call-A-Nurse in size, organizational structure, type of services provided, personnel employed, or geographical area....
> >
> > The Secretary's reliance on the Michigan Survey is especially troubling in light of the fact that the record contains a much more reliable means of determining the reasonableness of the salaries in question, namely, the Dunham evaluation.... Upon review of the entire record, the Court believes that on this issue the PRRB's determination was well-reasoned and should have been upheld by the Secretary.

59 F. Supp. 2d at 938.

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[13] See Addendum to Provider Exhibit 12.

DECISION AND ORDER:

The Intermediary's adjustments to owners' compensation were not proper. The Intermediary's determinations are modified to: (1) exclude the bonus payments of $60,000 from the compensation amounts; and (2) allow as reasonable owners' compensation the salary and benefits amounts of $94,000 and $70,000 for the Provider's CEO and CFO, respectively.

BOARD MEMBERS PARTICIPATING:

Irvin W. Kues
James G. Sleep
Henry C. Wessman, Esquire
Martin W. Hoover, Jr., Esquire
Charles R. Barker

Date of Decision: December 9, 1999

FOR THE BOARD

Irvin W. Kues
Chairman