PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2012-D19

PROVIDERS –
HCR Manor Care 1999 Laundry and Central Supply Statistics Group

Provider Nos.: See Appendix A

vs.

INTERMEDIARY –
BlueCross BlueShield Association/ Highmark Medicare Services

DATE OF HEARING –
December 10, 2007

Cost Reporting Period Ended - May 31, 1999

CASE NO.: 02-0387GC

INDEX

ISSUE:

Whether the Intermediary's adjustments to the Laundry and Linen and the Central Service and Supply statistics were proper.

MEDICARE STATUTORY AND REGULATORY BACKGROUND:

This is a dispute over the amount of Medicare reimbursement due a provider of medical services.

The Medicare program was established under Title XVIII of the Social Security Act, as amended (Act),[1] to provide health insurance to the aged and disabled. The Centers for Medicare & Medicaid Services (CMS), formerly the Health Care Financing Administration (HCFA), is the operating component of the Department of Health and Human Services (DHHS) charged with administering the Medicare program. CMS' payment and audit functions under the Medicare program are contracted to organizations known as fiscal intermediaries (FIs) and Medicare administrative contractors (MACs). FIs and MACs[2] determine payment amounts due the providers under Medicare law, regulation and interpretative guidelines published by CMS.[3]

Providers are required to submit cost reports annually, with reporting periods based on the provider's fiscal or accounting year. A cost report shows the costs incurred during the relevant fiscal year and the portion of those costs allocated to Medicare.[4] Each intermediary reviews the cost report, determines the total amount of Medicare reimbursement due the provider, and issues the provider a Notice of Program Reimbursement (NPR).[5]

A provider dissatisfied with the intermediary's final determination of total reimbursement (i.e., the NPR) may file an appeal with the Provider Reimbursement Review Board (Board) provided it meets the following conditions: (1) the provider must be dissatisfied with the final determination of the intermediary; (2) the amount in controversy is $10,000 or more for an individual appeal (or $50,000 for groups); and (3) the appeal must be filed with the Board within 180 days of the receipt of the final determination.[6]

For the cost reporting year under appeal, skilled nursing facilities (SNFs) were reimbursed the reasonable cost of providing services to Medicare beneficiaries. Congress defined "reasonable cost," in pertinent part, as follows:

> The reasonable cost of any services shall be the cost actually incurred, excluding therefrom any part of incurred cost found to be unnecessary in

---

[1] 42 U.S.C., Chapter 7, Subchapter XVIII.

[2] FIs and MACs are hereinafter referred to as intermediaries.

[3] *See* Social Security Act (Act) §§ 1816 and 1874A; 42 U.S.C. §§ 1395h and 1395kk-1; 42 C.F.R. §§ 413.20 and 413.24.

[4] *See* 42 C.F.R. § 413.20.

[5] *See* 42 C.F.R. § 405.1803.

[6] *See* § 1878(a) of the Act; 42 U.S.C. § 1395oo(a); 42 C.F.R. §§ 405.1835-1837.

> the efficient delivery of needed health services, and shall be determined in accordance with regulations establishing the method or methods to be used, and the items to be included, in determining such costs for various types or classes of institutions, agencies, and services. . . . Such regulations shall (i) take into account both direct and indirect costs of providers of services (excluding therefrom any such costs, including standby costs, which are determined in accordance with regulations to be unnecessary in the efficient delivery of services covered by the insurance programs established under this title) in order that, under the methods of determining costs, the necessary costs of efficiently delivering covered services to individuals covered by the insurance programs established by this title will not be borne by individuals not so covered, and the costs with respect to individuals not so covered will not be borne by such insurance programs. . . .[7]

The basic objective of these statutory provisions is to only pay for reasonable necessary costs in the efficient delivery of covered services and to prohibit cost shifting or cross-subsidization between Medicare and non-Medicare patients. These reimbursement principles are further explained in the regulations. 42 C.F.R. § 413.5(a) states that:

> In formulating methods for making fair and equitable reimbursement for services rendered beneficiaries of the program, payment is to be made on the basis of current costs of the individual provider, rather than costs of a past period or a fixed negotiated rate. All necessary and proper expenses of an institution in the production of services, including normal standby costs, are recognized. Furthermore, the share of the total institutional cost that is borne by the program is related to the care furnished beneficiaries so that no part of their cost would need to be borne by other patients. Conversely, costs attributable to other patients of the institution are not to be borne by the program. Thus, the application of this approach, with appropriate accounting support, will result in meeting actual costs of services to beneficiaries as such costs vary from institution to institution.

The cost finding process begins with the establishment of accounting categories called "cost centers" (e.g., general service, inpatient routine service, ancillary service, other reimbursable, and nonreimbursable cost centers). All direct costs are recorded in the appropriate cost centers, and a facility's indirect or general service costs (e.g., building depreciation, administrative and general expenses, and nursing administration) are then allocated to the revenue-producing departments.[8] Medicare cost reporting instructions set forth the allocation bases (square footage, accumulated cost, etc.) upon which, as well as the order in which, the non-revenue producing cost centers are allocated to the revenue-producing cost centers.[9] Once the total allowable costs of a provider's services have been ascertained and allocated to reimbursable cost centers, those

---

[7] § 1861(v)(1)(A) of the Act, 42 U.S.C. § 1395x(v)(1)(A).

[8] *See* 42 C.F.R. § 413.24(d)(1); Provider Reimbursement Manual, Part I (CMS Pub. 15-1) § 2306.

[9] *See* Provider Reimbursement Manual, Part II (CMS Pub.15-2) § 3524.

costs must then be apportioned between Medicare beneficiaries and non-Medicare patients (e.g., based on per-diem cost for routine room and board services and charges for ancillary services such as therapies or medical supplies).[10]

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

The Providers are Medicare-certified SNFs located in various states and operated by Manor Care Health Services (MCHS), a wholly-owned subsidiary of Manor Care, Inc. (MCI). In September 1998, Health Care and Retirement Corporation of America (HCR) merged with MCI to form HCR Manor Care.

The dispute in this case involves the Intermediary's adjustments related to the allocation statistics reported for the Laundry and Service and the Central Service and Supply cost centers.

The Providers individually appealed the Intermediary's adjustments to the allocation statistics used for the laundry and linen cost center and the central service and supply cost center, and on December 30, 2001, submitted a request to form a group appeal, to which the Board assigned Case No. 02-0387GC. The Providers estimated the reimbursement amount in dispute in this case to be $552,207.[11]

During the fiscal year in dispute, FYE May 31, 1999, CareFirst of Maryland, Inc. was the Intermediary responsible to finalize all cost reports that were part of the Manor Care chain organization.[12] In October 2005, Highmark Medicare Services assumed the responsibility for the Providers and this appeal.

The group appeal consisted of eighty-five Providers within the HCR Manor Care chain organization. On December 9, 2011, the Board found that it lacked jurisdiction under § 1878(a) of the Act[13] for both the laundry and central supply statistic issues for Arlington and Summer Trace and also lacked jurisdiction for the central supply statistic issue only for Allentown, Sinking Spring, and Sunbury. The Board also declined to exercise its discretionary power under § 1878(d) of the Act.[14] The remaining Providers timely appealed the Intermediary's determinations to the Board and met the jurisdictional requirements of 42 C.F.R. §§ 405.1835 – 405.1840.

A consolidated hearing was conducted on December 10, 2007, for five cases covering two issues across three fiscal years. Subsequent to the hearing, the parties agreed to enter into settlement discussions for a total of 33 Manor Care appeals and requested deferment of the Board's decision. On October 7, 2009, the Providers notified the Board that Case Nos. 00-1686GC, 00-3474GC, 00-1687GC, and 00-3475GC from the December 10, 2007, hearing and a number of

---

[10] *See* 42 C.F.R. § 413.50.

[11] *See* Schedule of Providers in Group at Appendix A.

[12] In April 1997, the Intermediary for the Providers changed from Aetna to CareFirst of Maryland, Inc.

[13] 42 U.S.C. § 1395oo(a).

[14] 42 U.S.C. § 1395oo(d).

other cases had been administratively resolved or withdrawn. On October 18, 2010, the Providers notified that Board that the parties were unable to resolve the remaining case referenced herein, and on January 28, 2011, the Providers requested that the Board issue its decision in this case. The sole issue remaining for the Board to adjudicate in Case No. 02-0387GC is whether the Intermediary's adjustments to the laundry and linen and central service and supply statistics were proper.

The parties stipulated to the following pertinent facts:[15]

- Laundry and linen and central service and supply costs can be allowable costs under Medicare.
- A Medicare fiscal intermediary has the authority to approve the use of alternate cost-allocation statistics.

The Providers were represented at hearing by Jason M. Healy, Esquire, and Catherine A. Durkin, Esquire, of Reed Smith, LLP, and subsequently represented by Scot T. Hassleman, Esquire, and Catherine A. Hurley, Esquire, of Reed Smith, LLP. The Intermediary was represented by Arthur E. Peabody, Jr., Esquire, of the Blue Cross Blue Shield Association.

PROVIDERS' CONTENTIONS:

The Providers contend that the cost allocation statistics used for the Laundry and Linen and Central Service and Supplies cost centers were appropriate. The Providers state that the traditional method (and that previously used by the Providers) of allocating the cost of laundry and linens in a SNF was to weigh all laundry actually used in the SNF and record the amounts in pounds of laundry attributable to Medicare beneficiaries and non-Medicare residents. The traditional method of allocating the Medicare portion of central service and supplies was costed requisitions. These methods were both labor and time intensive, and were thus administratively burdensome for the Providers to carry out. Therefore, the Providers indicate that they elected a simplified cost allocation methodology in accordance with the Medicare Provider Reimbursement Manual, Parts I and II (CMS Pubs. 15-1 and 15-2).[16] Accordingly, the Providers assert that the former Intermediary (Aetna) agreed to an alternate method of allocating the Medicare portion of these costs using patient days multiplied by a factor of 1.2 for laundry and linen and 1.5 for central service and supplies. Therefore, the Medicare portion of the facility received a 20 percent higher allocation of laundry costs and a 50 percent higher allocation of central supply costs.

The Providers argue that the higher allocations to the Medicare certified area were based on the Providers' actual experience with pounds of laundry used and central supplies utilized by Medicare beneficiaries. Because of higher acuity levels, the actual pounds of laundry used and central service and supplies consumed by Medicare beneficiaries were higher when compared to non-Medicare SNF residents. The Providers maintain that the propriety of such an approach is expressly contemplated by the Medicare regulations:

---

[15] Stipulation ¶¶ 6 and 7.

[16] *See* CMS Pub. 15-1 § 2312 and CMS Pub. 15-2 § 3617.

> A basic factor bearing upon the apportionment of costs is that Medicare beneficiaries are not a cross section of the total population. Nor will they constitute a cross section of all patients receiving services from most of the providers that participate in the program. Available evidence shows that the use of services by persons age 65 and over differs significantly from other groups. Consequently, the objective sought in the determination of the Medicare share of a provider's total costs means that the methods used for apportionment must take into account the differences in the amount of services received by patients who are beneficiaries and other patients serviced by the provider.[17]

The Providers claim that the Intermediary has not presented evidence that the cost allocation statistics used are prohibited. The Providers also indicate that the Intermediary has not suggested that the cost allocation statistics are significantly out of proportion to actual pounds of laundry and costed requisitions for Medicare beneficiaries in SNFs or are substantially out of line with similarly-situated SNFs. Further, the Providers argue that the Intermediary's position fails to acknowledge that Medicare beneficiaries have, on average, higher acuity levels and associated expenses related to patient care.

Second, the Providers contend that the cost allocation statistics were approved by the former Intermediary, and that the Providers, in good faith, relied on Aetna's past policies. In response to the Intermediary's claims that the Providers have not provided any documentation to support the prior approval for the cost allocation methods it used in its cost reports, the Providers point to Exhibits P-7 and P-8 to show that Aetna settled, without adjustment, a cost report for FYE October 31, 1993 that used the same cost allocation methods that the Intermediary now disputes. As further support, the Providers offer Exhibits P-9, P-10, and P-11, which are letters from Aetna instructing the Providers to use the cost allocation statistic used in previous years for central service and supplies. Although the letters did not expressly address laundry and linen costs, the Providers assert that, together with Exhibits P-7 and P-8, they do establish that Aetna agreed with and accepted the Providers' cost allocation statistics in prior years.

The Providers argue that they were entitled to rely on Aetna's prior policies with respect to cost allocation methods established for laundry and central supplies. The Providers believe that the subsequent Intermediary should have accepted the use of the same statistics to allocate the same costs, and the Providers also point out that CareFirst did in fact settle cost reports through FY 1996 using the Providers' existing statistical methodology.[18] The Providers argue that it was inconsistent for the Intermediary to suddenly adjust in FYs 1997, 1998, and 1999 the statistical

---

[17] 42 C.F.R. § 413.50(c).

[18] For example, Exhibits P-12 and P-13 show that the Intermediary finalized the reopened FYE 10/31/1995 cost report for Manor Care of Dunedin (Provider No. 10-5436), which used the same statistics, previously accepted by Aetna, without objection or adjustment to those statistics. Exhibit P-14 is the full finalized FY 1996 cost report for the same facility and Exhibit P-15 includes the S-3 and B-1 worksheets, which CareFirst accepted and settled. The Providers submit the documents at Exhibits P-12 through P-15 for the Dunedin facility as representative of the entire group of Providers whose cost reports for FY 1995 and FY 1996 were accepted and finalized by CareFirst without adjustment to the laundry/linen and central supply statistics.

method that Aetna and CareFirst had both previously accepted, without adequate notice to the Providers that alternate statistics (such as pounds of laundry and costed requisitions) would need to be maintained on a going forward basis.

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that the audit adjustments were based on a lack of documentation to justify the Providers' allocation methodology. The Intermediary states it was noted that during the desk reviews of the SNFs included in this appeal, the Providers had misstated the allocation basis headings reported on Worksheet B-1 of the cost reports. The Providers utilized neither pounds of laundry, nor costed requisitions, as required by cost reporting instructions.[19] Instead, they used patient days times 1.2 for laundry and times 1.5 for central supply for allocation of these costs to the certified skilled nursing cost center. However, the Providers used unweighted patient days for the allocation of these costs to the non-certified nursing facility cost center.

The Intermediary asserts that the Providers could not document the recommended statistical basis, could not provide documentation to support why the skilled nursing cost center should receive a higher allocation than the non-certified nursing facility cost center for these services, and could not supply documentation to support the prior Intermediary's approval of the alternative statistical method. Therefore, the Intermediary made adjustments to the statistical bases on Worksheet B-1 so that they agreed to patient days as reported on Worksheet S-3. CMS Pub. 15-1 § 2313 states, "[i]f a provider has submitted a cost report with a change in its allocation statistics and/or order of allocation without prior approval from its intermediary, the intermediary must reject the cost report." The Intermediary believes that it acted fairly by allocating the laundry and central service costs based on patient days from Worksheet S-3, as compared to the alternative of a total disallowance of the expenses.

The Intermediary contends that the Providers are attempting to shift non-Medicare costs to the Medicare program. The goal in classifying costs to departments accurately is to ensure that Medicare pays its fair share of those costs, and no more or less. To effect an accurate allocation, logical statistical bases have been recommended. However, the recommended bases were not used by the Providers. Instead, the Intermediary alleges that the Providers weighted the patient days to inflate the costs being allocated to the Medicare patients in the skilled nursing cost center. At the same time, they used an unweighted statistic to reduce costs allocated to non-Medicare patients in the nursing facility cost center.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

After considering the Medicare law and program instructions, the evidence presented and the parties' contentions, the Board finds and concludes that the Intermediary's adjustments to the Providers' statistical bases were proper.

Worksheet B, Part I, of the SNF cost report (Form CMS-2540-96) provides for the allocation of the expenses of each general service cost center to those cost centers which receive the services.

---

[19] *See* CMS Pub 15-2 § 3524.

Worksheet B-1 provides for the statistical data needed to equitably allocate the expenses of the general service cost centers on Worksheet B, Part I. 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.[20] There is no dispute that the recommended allocation bases for the Laundry and Linen Service and Central Service and Supply cost centers are "Pounds of Laundry" and "Costed Requisitions," respectively.

In this case, the Providers did not use the prescribed allocation statistics for the Laundry and Linen or the Central Services and Supplies cost centers. Instead, to allocate costs to the certified skilled nursing cost center,[21] the Providers used an alternative statistic based on patient days multiplied by a weighting factor of 1.2 for Laundry and Linen and 1.5 for Central Service and Supplies. The Providers used unweighted patient days for the allocation of both laundry and supplies to the non-certified nursing facility cost center.[22] The Providers base their arguments for using these alternate cost finding methods on the Medicare regulation 42 C.F.R. § 413.50(c) that acknowledges Medicare beneficiaries are not typical of the population and costs of care are often greater for Medicare beneficiaries.[23] The Providers justify the change in statistical bases as being more equitable such that the prescribed methods were no longer appropriate and necessary.[24]

Pursuant to 42 C.F.R. § 413.24(d)(2)(ii), "[a] more sophisticated method designed to allocate costs more accurately may be used by the provider upon approval of the intermediary" but "[w]ritten request for the approval must be made on a prospective basis and must be submitted before the end of the fourth month of the prospective reporting period." The Provider Reimbursement Manual sets forth the procedures by which a provider may request such a change to the basis for allocating a cost center. In relevant part, the manual provides that:

> When a provider wishes to change its statistical allocation basis for a particular cost center and/or the 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 intermediary has sixty (60) days from receipt of the request to make a decision or the change is automatically accepted. The provider must include with the request all supporting documentation to establish that the new method is more accurate. . . .
>
> If a provider has requested a change in allocation bases, the provider must maintain both sets of statistics until an approval is granted. If the request

---

[20] *Id.*

[21] Transcript (Tr.) at 31, 37.

[22] Tr. at 39-40.

[23] Tr. at 28-29.

[24] Tr. at 42-44, 100.

> is denied, the provider reverts back to the previously approved methodology. If the provider has failed to maintain the statistics per the previously approved methodology, the fiscal intermediary may accept the previous year's statistics, if the prior year's statistics can be reasonably related to the current year's costs. Otherwise, the incremental program costs associated with the unapproved change must be disallowed. If the provider continues to use the unapproved statistics/methodology for the subsequent year, all costs and statistics will be disallowed for those cost centers affected by the unapproved change. This requirement will apply to all cost finding methods.
>
> The intermediary's approval of a provider's request will be furnished to the provider in writing within sixty (60) days of receipt of the request. Where the intermediary approves the provider's request, the change must be applied to the cost reporting period for which the request was made and to all subsequent cost reporting periods unless the intermediary approves a subsequent request for change by the provider. The effective date of the change will be the beginning of the cost reporting period for which the request has been made. . . .
>
> If a provider has submitted a cost report with a change in its allocation statistics and/or order of allocation without prior approval from its intermediary, the intermediary must reject the cost report. If the provider can prove that the change results in a more appropriate and more accurate allocation of cost, is supported by adequate auditable documentation, and meets all the other conditions of this chapter, the fiscal intermediary may accept the provider's change upon resubmission of the cost report, notwithstanding the lack of prior approval.[25]

Although the Providers have testified that "the Intermediary and the Provider came to some agreement that it was an appropriate statistic,"[26] the Providers could not document that a request to change the method at issue was submitted to and approved by the Intermediary. The Providers speculate this occurred but could not offer reliable evidence that it did in fact occur.[27]

The Board finds that the absence of prior written approval is not sufficient in itself to disallow the use of alternative allocation statistics. This position is reinforced by a CMS letter dated March 31, 1995[28], which states in part:

> [f]inally, you are concerned that the provider ignored a threshold requirement of PRM section 2307 by failing to obtain prior approval from

---

[25] CMS Pub. 15-1 § 2313.

[26] Tr. at 69.

[27] Tr. at 69-71, 88-89, 101-102, 113-114.

[28] As quoted in *Christ the King Manor v. Blue Cross and Blue Shield Association/Veritus Medicare Services*, PRRB Dec. No. 2003-D10 at 7-8 (Dec. 20, 2002).

> the fiscal intermediary to use direct assignment of costs. While we [CMS] believe that this is an important requirement that should not be ignored by providers, our enforcement of this requirement has been reshaped by practical considerations. We have never been sustained on appeal in situations where failure to obtain prior written approval is the only defect in a provider's use of a cost allocation alternative. The PRRB has adopted a "no harm, no foul" approach to enforcing this requirement. That is, as long as the provider's cost allocation alternative produces a more appropriate and more accurate allocation of cost, and is supported by adequate, auditable documentation, the provider's alternative has been accepted. We believe that further appeals based solely on the lack of prior approval would be futile. Therefore, you may advise Blue Cross of California (BCC) that, if a particular cost allocation alternative elected by a provider under section 2307 results in a more appropriate and more accurate allocation of cost, is supported by adequate, auditable documentation, and meets all the other requirements of section 2307, BCC may accept the provider's alternative, notwithstanding the lack of prior approval.

Therefore, even if prior Intermediary approval is not absolutely necessary as a prerequisite to the use of an alternative method, the new method must be documented as more accurate and sophisticated than the prescribed method, not just more convenient for the Provider.

The Providers' testimony indicates that the weighting factors were derived from the historical experience of the facilities with actually weighing pounds of laundry and utilizing costed requisitions.[29] The Providers claim that the alternative statistics were not simply a measure of patient days, but were designed to estimate the pounds of laundry and costed requisitions without going through the extra work to maintain the actual statistics.[30] However, the major issue is whether the weighting factors developed for the patient days in the skilled nursing area: (i) are relevant to 1999 since they were developed some time prior to 1995;[31] (ii) accurately measure the difference in usage of these services between the certified and non-certified areas; and (iii) are more accurate than the prescribed statistics.

There is no evidence in the record supporting the development of the alternative statistics as an accurate representation of actual laundry or supply usage. Further, the Provider was unaware of and could not describe what evidence, if any, was furnished to the Intermediary when the change occurred.[32] Assuming, *arguendo*, that the alternative method had been a close approximation in the year the method was established, the Providers supplied no evidence to support that its method would continue to be similarly representative for any subsequent periods or whether there had been any studies to support the ongoing use of the alternative methodology as accurate.

---

[29] Tr. at 42-44, 82.

[30] Tr. at 43-45, 78, 82.

[31] Tr. at 68-70.

[32] Tr. at 69-71.

The Providers were unable to address these issues beyond speculating the alternative methods are simpler and less burdensome to maintain.[33]

The Providers state that they "elected a simplified cost allocation methodology" in accordance with CMS Pub. 15-1 § 2312, and CMS Pub. 15-2 § 3617.[34] The Intermediary relied on these same manual provisions to adjust the allocation statistics to reflect unweighted patient days for both the certified and non-certified cost centers.[35] The "simplified cost allocation methodology" specifically provides for the use of "patient days" as an alternative statistic for the Laundry and Linen cost center, but there is no provision for weighting or otherwise marking-up the number of patient days to derive an alternate proxy statistic.[36] There is no alternative statistic available in the simplified methodology for Central Service and Supply as the approved statistic listed is the standard "costed requisitions" statistic.[37] However, the Intermediary states that it used patient days for both cost centers as an alternative to disallowing the statistic in total.[38] The Board notes that, while the simplified methodology as referenced in CMS Pub. 15-1 § 2313 and CMS Pub. 15-2 § 3617 specifically addresses statistical allocations within hospital facilities,[39] both parties reference these manual sections as an acceptable cost finding methodology that could also be adapted to SNFs.

In this case, the Board finds that the Providers failed to demonstrate that the patient day weighting was a more accurate and sophisticated measure than the allocation bases required by the cost reporting instructions. The Providers were also unable to furnish auditable documentation to support the development or the ongoing accuracy of the weighting factors. Therefore, the Intermediary's adjustment to the filed allocation statistics for the Laundry and Linen and the Central Service and Supply cost centers was proper. Further, given the Providers' lack of documentation to support the prescribed allocation statistics and the Provider' stated goal of "eas[ing] the administrative burdens of weighing laundry and tracking costed requisitions,"[40] the Board finds the Intermediary's use of unweighted patient days to be a reasonable alternative based on the simplified cost allocation methodology in CMS Pub 15-2, § 3617.

---

[33] Tr. at 100. *See also* Providers' Consolidated Reply Brief at 2; Providers' Consolidated Revised Position Paper at 4.

[34] Providers' Consolidated Reply Brief at 2.

[35] *See* Intermediary Position Paper Revised at 6; Exhibit I-94.

[36] CMS Pub. 15-2 § 3617. Within this section, there is no provision for weighting or otherwise marking-up the number of patient days to derive an alternate proxy statistic.

[37] CMS Pub. 15-2 § 3617. Within this section, there is no provision for weighting or otherwise marking-up the number of patient days to derive an alternate proxy statistic.

[38] Intermediary Position Paper Revised at 12.

[39] *See* CMS Pub. 15-1 § 2313 ("If the provider is requesting the simplified method (hospitals only), as described in HCFA Pub. 15-II, Chapter 36, § 3617, the provider must demonstrate that the maintenance of the new statistics is less costly."). *See also* CMS Pub. 15-2 Chapter 36, Hospital and Hospital HealthCare Complex Cost Report (Form CMS 2552-96, Instructions & Specifications).

[40] Providers' Consolidated Revised Position Paper at 4.

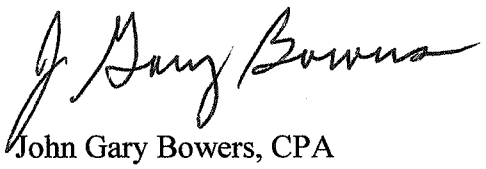
DECISION AND ORDER:

The Intermediary properly adjusted the Providers claimed allocation statistics for the Laundry and Linen and the Central Service and Supply cost centers. The Intermediary's adjustments are affirmed.

BOARD MEMBERS PARTICIPATING:

Keith E. Braganza, CPA
John Gary Bowers, CPA
Clayton J. Nix, Esq.

FOR THE BOARD:



John Gary Bowers, CPA
Board Member

DATE: JUL 19 2012

Schedule of Providers in Group (Schedule A)

Group Name: HCR ManorCare 99 Laundry & Supply Stats
Representative: Reed Smith LLP
Case Number: 02-0387G **Issue: 99 Laundry and Central Supply Stats** **Date Prepared: 09/30/05**

	Provider Number	Provider Name	FYE	Intermediary	A Date of Final Determination	B Date of Hearing Rqst	C No. of Days	D Audit Adjustment Number	E Approximate Amount (Footnote 1)	F Original Case Number (Footnote 2)	G Date of Addition/ Transfer	
1	39-5760	Allentown Allentown, Lehigh, PA	05/31/1999	CareFirst of Maryland	09/20/2001	03/13/2002	173	3	14,045	02-1108	07/23/2002	42
2	15-5005	Anderson Anderson, Madison, IN	05/31/1999	CareFirst of Maryland	03/28/2001	09/18/2001	170	5	4,173	01-3505	01/29/2002	
3	52-5264	Appleton Appleton, Outgamie, WI	05/31/1999	CareFirst of Maryland	06/26/2001	12/20/2001	174	4	3,645	02-0380	04/30/2002	
4	49-5102	Arlington Arlington, Arlington, VA	05/31/1999	CareFirst of Maryland	09/26/2001	01/30/2002	124	16	387	02-0653	06/28/2002	43
5	14-5199	Arlington Heights Arlington Heights, Cook, IL	05/31/1999	CareFirst of Maryland	02/28/2001	07/31/2001	150	4	15,206	01-3287	01/29/2002	
6	39-5731	Bethel Park Bethel Park, Allegheny, IL	05/31/1999	CareFirst of Maryland	09/17/2001	03/13/2002	176	3	11,770	02-1107	07/23/2002	
7	39-5429	Bethlehem I Bethlehem, Lehigh, PA	05/31/1999	CareFirst of Maryland	03/26/2001	09/20/2001	174	3	9,017	01-3513	01/29/2002	
8	39-5527	Bethlehem II Bethlehem, Lehigh, PA	05/31/1999	CareFirst of Maryland	03/22/2001	09/17/2001	175	3	6,751	01-3472	01/29/2002	
9	32-5042	Camino Vista Albuquerque, Bernalillo, NM	05/31/1999	CareFirst of Maryland	06/26/2001	12/20/2001	174	6	931	02-0383	04/30/2002	
10	39-5746	Carlisle Carlisle, Cumberland, PA	05/31/1999	CareFirst of Maryland	09/17/2001	03/13/2002	176	2	1,377	02-1106	07/23/2002	
11	36-6100	Centerville Centerville, Montgomery, OH	05/31/1999	CareFirst of Maryland	05/10/2001	11/01/2001	171	4	7,963	02-0211	03/27/2002	
12	39-5348	Chambersburg Chambersburg, Franklin,PA	05/31/1999	CareFirst of Maryland	02/28/2001	08/24/2001	174	4	1,217	01-3374	01/29/2002	
13	14-5190	Champaign Champaign, Champaign, IL	05/31/1999	CareFirst of Maryland	01/30/2001	07/25/2001	175	3	4,799	01-3232	01/29/2002	
14	42-5362	Charleston Charleston, Charleston, SC	05/31/1999	CareFirst of Maryland	02/08/2001	07/31/2001	173	3	672	01-3289	12/20/2001	
15	42-5008	Columbia Columbia, Howard, SC	05/31/1999	CareFirst of Maryland	09/13/2001	01/30/2002	137	4	13,434	02-0654	06/24/2002	
16	16-5033	Davenport Davenport, Scott, IA	05/31/1999	CareFirst of Maryland	04/26/2001	08/29/2001	123	4	4,937	01-3384	04/30/2002	
17	11-5246	Decatur Decatur, Dekalb, GA	05/31/1999	CareFirst of Maryland	01/30/2001	07/25/2001	175	3	5,266	01-3230	01/29/2002	
18	14-5038	Decatur Decatur, Macon , IL	05/31/1999	CareFirst of Maryland	02/09/2001	07/31/2001	172	1	4,841	01-3285	01/29/2002	
19	16-5104	Dubuque Dubuque, Dubuque, IA	05/31/1999	CareFirst of Maryland	04/26/2001	08/28/2001	122	2	8,611	01-3382	04/30/2002	
20	39-5540	Easton Easton, N. Hampton, PA	05/31/1999	CareFirst of Maryland	06/13/2001	12/06/2001	173	3	7,112	02-0287	04/30/2002	
21	14-5004	Elgin Elgin, Kane, IL	05/31/1999	CareFirst of Maryland	02/05/2001	07/31/2001	176	2	3,793	01-3290	12/20/2001	
22	14-5689	Elk Grove Village Elk Grove Village, Cook, IL	05/31/1999	CareFirst of Maryland	03/22/2001	09/17/2001	175	2	7,775	01-3491	01/29/2002	

[42] The Board found that it lacks jurisdiction for the Central Supply Statistic issue only for Allentown.

[43] The Board found that it lacks jurisdiction for both the Laundry and Central Supply Statistic issues for Arlington.

23	26-5112	Florissant Florissant, St Louis, MO	05/31/1999	CareFirst of Maryland	05/31/2001	11/26/2001	176	1	5,423	02-0247	03/27/2002
24	52-5274	Fond du Lac Fond du Lac, Fond du Lac, WI	05/31/1999	CareFirst of Maryland	06/26/2001	12/20/2001	174	1	4,474	02-0382	04/30/2002
25	52-5232	Green Bay West Green Bay, Brown, WI	05/31/1999	CareFirst of Maryland	03/22/2001	08/30/2001	158	3	10,340	02-1935	08/29/2002
26	39-5395	Harrisburg Harrisburg, Dauphin, PA	05/31/1999	CareFirst of Maryland	02/01/2001	07/27/2001	176	4	9,773	01-3233	01/29/2002
27	39-5913	Huntingdon Valley Huntingdon Valley, Montgomery, PA	05/31/1999	CareFirst of Maryland	08/13/2001	01/31/2002	168	3	10,719	02-0305	06/28/2002
28	49-5283	Imperial Richmond, Richmond, VA	05/31/1999	CareFirst of Maryland	02/28/2001	07/31/2001	150	3	12,803	01-3288	01/29/2002
29	15-5169	Indianapolis North Indianapolis, Marion, IN	05/31/1999	CareFirst of Maryland	04/18/2001	09/27/2001	159	2	8,477	01-3559	03/01/2002
30	15-5247	Indianapolis South Indianapolis, Marion, IN	05/31/1999	CareFirst of Maryland	04/18/2001	09/27/2001	159	4	4,158	01-3558	03/01/2002
31	39-5359	Jersey Shore Jersey Shore, Lycoming, PA	05/31/1999	CareFirst of Maryland	03/07/2001	08/28/2001	171	2	202	01-3383	01/29/2002
32	14-5043	Kankakee Kankakee, Kankakee, IL	05/31/1999	CareFirst of Maryland	03/28/2001	09/18/2001	170	3	4,276	01-3503	01/29/2002
33	39-5834	King of Prussia King of Prussia, Montgomery, PA	05/31/1999	CareFirst of Maryland	12/27/2000	06/21/2001	174	3	8,798	01-3090	01/29/2002
34	39-5037	Kingston Court York, York, PA	05/31/1999	CareFirst of Maryland	12/27/2000	06/21/2001	174	2	4,502	01-3091	01/29/2002
35	39-5397	Kingston East Kingston, Luzerne, PA	05/31/1999	CareFirst of Maryland	03/26/2001	09/20/2001	174	4	2,803	01-3514	01/29/2002
36	15-5064	Kokomo Kokomo, Howard, IN	05/31/1999	CareFirst of Maryland	03/28/2001	09/18/2001	170	4	4,173	01-3500	01/29/2002
37	36-5594	Lake Shore Cleveland, Cuyahoga, OH	05/31/1999	CareFirst of Maryland	06/26/2001	12/05/2001	159	3	4,100	02-0333	03/27/2002
38	21-5104	Largo Largo, Prince Georges, MD	05/31/1999	CareFirst of Maryland	03/07/2001	08/24/2001	167	4	8,216	01-1016	03/27/2002
39	39-5477	Laureldale Laureldale, Berks, PA	05/31/1999	CareFirst of Maryland	03/26/2001	09/20/2001	174	4	6,115	01-3515	01/29/2002
40	39-5472	Lebanon Lebanon, Lebanon, PA	05/31/1999	CareFirst of Maryland	09/20/2001	03/14/2002	174	3	2,543	02-1103	07/23/2002
41	42-5105	Lexington West Columbia, Lexington, SC	05/31/1999	CareFirst of Maryland	12/27/2000	06/22/2001	175	4	11,569	01-3119	01/29/2002
42	14-5593	Libertyville Libertyville, Lake, IL	05/31/1999	CareFirst of Maryland	03/28/2001	09/18/2001	170	4	10,507	01-3501	01/29/2002
43	52-5266	Madison Madison, Dane, WI	05/31/1999	CareFirst of Maryland	06/28/2001	12/20/2001	172	3	4,899	02-0381	04/30/2002
44	11-5283	Maristta Maristta, , GA	05/31/1999	CareFirst of Maryland	05/21/2001	09/27/2001	126	5	21,697	01-3557	03/01/2002
45	39-5989	Mercy Fitzgerald Yeadon, Delaware, PA	05/31/1999	CareFirst of Maryland	07/16/2001	01/10/2002	174	2	11,901	02-0469	05/31/2002
46	37-5098	Midwest City Oklahoma City, Oklahoma, OK	05/31/1999	CareFirst of Maryland	02/01/2001	07/18/2001	167	1	3,081	01-0706	12/20/2001
47	14-5045	Naperville Naperville, Dupage, IL	05/31/1999	CareFirst of Maryland	01/30/2001	07/25/2001	175	4	8,015	01-3231	01/29/2002
48	14-5031	Normal Normal, McClean, IL	05/31/1999	CareFirst of Maryland	03/22/2001	09/17/2001	175	2	966	01-3493	01/29/2002
49	37-5070	Norman Norman, Cleveland, OK	05/31/1999	CareFirst of Maryland	02/09/2001	07/18/2001	159	2	3,510	01-0707	12/20/2001
50	39-5826	North Hills Montgomerville, Allegheny, PA	05/31/1999	CareFirst of Maryland	12/27/2000	06/20/2001	173	4	8,326	01-3088	01/29/2002

51	36-5310	North Olmsted North Olmsted, Cuyahoga, OH	05/31/1999	CareFirst of Maryland	06/26/2001	12/05/2001	159	6	5,819	02-0334	03/27/2002	
52	36-5453	Oregon Oregon, Lucas, OH	05/31/1999	CareFirst of Maryland	08/22/2001	12/05/2001	163	3	4,298	02-0335	03/27/2002	
53	14-5039	Peoria Peoria, Peoria, IL	05/31/1999	CareFirst of Maryland	01/31/2001	07/25/2001	175	4	1,725	01-3229	01/29/2002	
54	08-5033	Pike Creek Wilmington, New Castle, DE	05/31/1999	CareFirst of Maryland	02/09/2001	08/07/2001	178	4	7,621	01-3292	04/30/2002	
55	34-5177	Pinehurst Pinehurst, Moore, NC	05/31/1999	CareFirst of Maryland	08/07/2001	01/30/2002	173	2	8,876	02-0652	06/28/2002	
56	39-5344	Pottsville Pottsville, Schuylkill, PA	05/31/1999	CareFirst of Maryland	02/09/2001	08/06/2001	177	2	9,203	01-3291	01/29/2002	
57	14-5524	Riverview East Peoria, Tazwell, IL	05/31/1999	CareFirst of Maryland	03/28/2001	09/18/2001	170	4	6,224	01-3504	01/29/2002	
58	36-5392	Rocky River Cleveland, Cuyahoga, OH	05/31/1999	CareFirst of Maryland	05/21/2001	11/15/2001	174	2	9,412	02-0281	03/27/2002	
59	14-5350	Rolling Meadow Rolling Meadows, Cook, IL	05/31/1999	CareFirst of Maryland	03/12/2001	09/07/2001	175	5	7,287	01-3451	01/29/2002	
60	21-5077	Ruxton Towson, Baltimore, MD	05/31/1999	CareFirst of Maryland	05/08/2001	11/02/2001	174	3	11,753	02-0170	03/27/2002	
61	32-5041	Sandia Albuquerque, Bernalico, NM	05/31/1999	CareFirst of Maryland	07/24/2001	12/20/2001	146	5	2,322	02-0378	04/30/2002	
62	39-5541	Sinking Spring Sinking Spring, Berks, PA	05/31/1999	CareFirst of Maryland	06/13/2001	12/06/2001	173	4	6,742	02-0288	04/30/2002	44
63	14-5869	Skokie Skokie, Cook, IL	05/31/1999	CareFirst of Maryland	03/22/2001	09/17/2001	175	4	12,125	01-3492	01/29/2002	
64	26-5188	Springfield Springfield, Greene, MO	05/31/1999	CareFirst of Maryland	08/07/2001	11/26/2001	109	4	6,225	02-0246	03/27/2002	
65	49-5045	Stratford Hall Richmond, Richmond, VA	05/31/1999	CareFirst of Maryland	02/05/2001	07/31/2001	176	2	10,267	01-3286	01/29/2002	
66	15-5618	Summer Trace Carmel, Hamilton, IN	05/31/1999	CareFirst of Maryland	08/20/2001	01/30/2002	160	5	4,306	02-0651	06/24/2002	45
67	39-5512	Sunbury Sunbury, Northumber, PA	05/31/1999	CareFirst of Maryland	03/22/2001	09/17/2001	175	3	4,530	01-3471	01/29/2002	46
68	21-5054	Towson Towson, Baltimore, MD	05/31/1999	CareFirst of Maryland	04/26/2001	08/28/2001	122	3	999	01-1014	03/27/2002	
69	37-5094	Tulsa Tulsa, Tulsa, OK	05/31/1999	CareFirst of Maryland	02/05/2001	07/18/2001	163	2	1,044	01-0705	12/20/2001	
70	14-5287	Urbana Urbana, Champaign, IL	05/31/1999	CareFirst of Maryland	03/28/2001	09/18/2001	170	4	4,617	01-3502	01/29/2002	
71	39-5351	West Reading West Reading, Berkes, PA	05/31/1999	CareFirst of Maryland	01/31/2001	07/27/2001	177	4	858	01-3234	01/29/2002	
72	36-5206	Westerville Westerville, Delaware, OH	05/31/1999	CareFirst of Maryland	07/24/2001	01/16/2002	172	4	10,161	02-0482	05/31/2002	
73	21-5048	Wheaton Wheaton, Montgomery, MD	05/31/1999	CareFirst of Maryland	04/18/2001	08/24/2001	126	3	4,977	01-3372	04/30/2002	
74	39-5199	Whitehall Lancaster, Lancaster, PA	05/31/1999	CareFirst of Maryland	12/27/2000	06/20/2001	173	1	4,231	01-3087	01/29/2002	
75	39-5396	Williamsport South Williamsport, Lycoming, PA	05/31/1999	CareFirst of Maryland	03/22/2001	09/17/2001	175	3	1,655	01-3473	01/29/2002	
76	14-5932	Wilmette Wilmette, Cook, IL	05/31/1999	CareFirst of Maryland	03/26/2001	09/18/2001	172	4	2,141	01-3506	01/29/2002	
77	23-5487	Windemere West Bloomfield, Oakland, MI	05/31/1999	CareFirst of Maryland	07/31/2001	12/20/2001	140	7	28,240	02-0379	04/30/2002	
78	36-5738	Woodridge Fairfield, Butler, OH	05/31/1999	CareFirst of Maryland	09/26/2001	02/16/2002	140	4	1,113	02-0829	07/23/2002	

[44] The Board found that it lacks jurisdiction for the Central Supply Statistic issue only for Sinking Spring.

[45] The Board found that it lacks jurisdiction for both the Laundry and Central Supply Statistic issues for Summer Trace.

[46] The Board found that it lacks jurisdiction for the Central Supply Statistic issue only for Sunbury.

79	36-5186	Woodside Madiera, Hamilton, OH	05/31/1999	CareFirst of Maryland	09/17/2001	02/16/2002	149	3	5,829	02-0830	07/23/2002
80	39-5817	Yardley Yardley, Lower Buck, PA	05/31/1999	CareFirst of Maryland	09/18/2001	03/14/2002	176	3	12,656	02-1105	07/23/2002
81	39-5374	Yeadon Yeadon, Delaware,PA	05/31/1999	CareFirst of Maryland	03/22/2001	09/17/2001	175	4	5,784	01-3474	01/29/2002
82	39-5442	York North York, York, PA	05/31/1999	CareFirst of Maryland	09/18/2001	03/14/2002	176	3	10,496	02-1104	07/23/2002
83	39-5309	York South York, York, PA	05/31/1999	CareFirst of Maryland	12/27/2000	06/21/2001	174	3	3,247	01-3089	01/29/2002
84	36-5355	Mayfield Heights Mayfield Heights, Cuyahoga, OH	05/31/1999	CareFirst of Maryland	05/21/2001	11/15/2001	174	4	12,076	02-0280	03/27/2002
85	39-5402	Pottstown Pottstown, Montgomery, PA	05/31/1999	CareFirst of Maryland	03/26/2001	09/20/2001	174	3	2,732	01-3516	01/29/2002
									552,207		

Footnotes

1 The calculated reimbursement impact by Provider is filed at Exhibit CC in lieu of individual Exhibit Es for each Provider.

2 PRRB acknowledgement letter of individual appeal is being provided in most cases, but is not required by the PRRB Instructions to prove jurisdiction.

List of Exhibits

AA Initial Request for Group Appeal dated December 20, 2001

BB PRRB Acknowledgement of Group Appeal letter dated January 8, 2002

CC Calculation of Reimbursement Impact by Provider