PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2003-D27

PROVIDER –
Home Town Health Care
Colonial Heights, Virginia

Provider No. 49-7259

vs.

INTERMEDIARY –
Blue Cross Blue Shield Association/
Cahaba Government Benefit
Administrators

DATE OF HEARING -
April 10, 2002

Cost Reporting Period Ended -
December 31, 1997

CASE NO. 00-2949

INDEX

ISSUES:

1. Whether the Intermediary's adjustment to disallow advertising cost was proper.

2. Whether the Intermediary's adjustment to include Heaven Sent Nursing Services as a non-reimbursable cost center was proper.

3. Whether the Intermediary's adjustment to reclassify the Community Education Coordinator's salary to a non-reimbursable cost center was proper.

4. Whether the Intermediary's adjustment to remove the Administrator's excess compensation was proper.

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Home Town Health Care ("Provider") is a freestanding, proprietary Medicare certified home health agency located in Colonial Heights, Virginia. The Provider's Medicare cost report for the year ended December 31, 1997 was audited by Cahaba Government Benefit Administrators ("Intermediary"). On September 27, 1999, the Intermediary issued a Notice of Program Reimbursement ("NPR") for the year at issue. On March 30, 2000, the Provider appealed the Intermediary's adjustments to the Provider Reimbursement Review Board ("Board") and has met the jurisdictional requirements of 42 C.F.R. §§ 405.1835-.1841. The estimated Medicare reimbursement impact of the adjustments is approximately $400,000. The Provider was represented by Mr. James S. Cowen, Esq. The Intermediary was represented by Eileen Bradley, Esq.

Issue No. 1 – Advertising

FACTS:

Upon audit the Intermediary disallowed $7,391 of the advertising costs based upon its determination that the costs were incurred to increase the Provider's patient utilization.

PROVIDER'S CONTENTIONS:

The Provider contends that the advertisement at issue (a television spot) was to enhance its public image as well as the public image of home health care providers generally. Primary sources of referrals to the Provider's agency came from two hospitals in the Colonial Heights, Virginia area. In 1997, those hospitals established their own home health agencies which led to a corresponding decrease in referrals to the Provider. In response, the Provider created a brief television spot to show that the public has a choice of home health care providers. This television spot was then played on two separate television stations in the local area for approximately two months.

The Provider relies on CMS Pub. 15-1 § 2136 which states that:

> [t]he allowability of advertising costs depends on whether they are appropriate and helpful in developing, maintaining and furnishing covered services to Medicare beneficiaries by providers of services.

The Provider asserts that at the very foundation of medical care is the realization on the part of the consumer that he or she can choose the care-giver. The Provider, through its television spot, was informing Medicare beneficiaries that they had choices; they were not limited in the local area to one agency. And while Provider concedes that its own agency's name was displayed at the end of the spot, its primary purpose was to inform consumers of choice.

In addition, CMS Pub. 15-1 § 2136.1 allows advertising in conjunction with an agency's public relations if the advertising is concerned with the presentation of a good public image and is related to patient care. The Provider contends that the entire focus of the televsion spot was to show a key component of patient care is the ability to choose one's own provider. The advertisement enhanced the public image of not only the Provider's agency but all home health agencies by virtue of making the public aware of the availability of alternative home health agencies.

The Provider further contends that the TV spot was comparable, in part, to a radio spot the Board ruled allowable in Cabarrus County Home Health Agency, Concord, NC v. Palmetto Government Benefits Administrator, PRRB Dec. No. 2000-D31, March 23, 2000, Medicare & Medicaid Guide (CCH) ¶ 80,421, rev'd, CMS Admin., May 24, 2000, Medicare & Medicaid Guide (CCH) ¶ 80,532. In that case the Provider utilized radio spots to recruit employees. The intermediary disallowed the expenses, claiming that the provider attempted to disguise advertising aimed at increasing patient utilization by including a few lines with respect to recruiting employees. The Board disagreed with the intermediary and found the fundamental purpose was to recruit personnel, but the Board added the following paragraph at the end of its decision:

> Moreover, the Board notes that advertising costs incurred by a provider in connection with its public relations activities are also allowable. While the Board rests solely upon its finding that the purpose of the subject advertisements is to recruit personnel, the Board believes the same characteristics of the ads relied upon by the Intermediary, and leading to the Intermediary's disallowances, could just as well be construed as an effort by the Provider to present a good public image as part of its recruitment campaign.

Id. emphasis added.

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that the documentation submitted by the Provider indicated that the cost was for non-allowable advertising to the general public, in that the television spots promoted an increase in patient utilization. The Intermediary points to the following in support of its adjustment:

> [n]ecessary and proper costs are . . . appropriate and helpful in developing and maintaining the operation of patient care facilities and activities. They are usually costs that are common and accepted occurences in the field of the provider's activity.

42 C.F.R. § 413.9

CMS Pub. 15-1 § 2136 states that:

> [t]he allowability of advertising costs depends on whether they are appropriate and helpful in developing, maintaining, and furnishing the covered services to Medicare beneficiaries by providers of services. In determining the allowability of these costs, the intermediary should consider the facts and circumstances of each provider situation as well as the amounts which would ordinarily be paid for comparable services by comparable institutions. To be allowable, such costs must be common and accepted occurences in the field of the provider's activity.

The Intermediary also relies on CMS Pub. 15-1 § 2136.1. It defines allowable advertising as:

> [a]dvertising costs incurred in connection with the provider's public relations activities are allowable if the advertising is primarily concerned with the presentation of a good public image and directly or indirectly related to patient care.

CMS Pub. 15-1 § 2136.2 further defines unallowable advertising as:

> [c]osts of advertising to the general public which seeks to increase patient utilization of the provider's facilities are not allowable. Situations may occur where advertising which appears to be in the nature of the provider's public relations activity is, in fact, an effort to attract more patients. An analysis by the intermediary of the advertising copy and its distribution may then be necessary to determine the specific objective. While it is the policy of the Health Care Financing Administration and other Federal agencies to promote the growth and expansion of needed provider facilities,

general advertising to promote an increase in the patient uilization of services is not properly related to the care of patients.

The Intermediary contends that the Provider's advertising is geared toward the general public, rather than a targeted viewer in need of home health care. Accordingly, as the advertisement serves to increase patient utilization, its cost is not allowable.

Issue No. 2. –Creation of a Non-reimbursable Cost Center

FACTS:

The Intermediary determined that two Provider employees performed services for another related organization. A non-reimbursable cost center for a related organization (Heaven Sent Nursing Services) was created wherein the Administrator's and Controller's salaries were placed.

PROVIDER'S CONTENTIONS:

The Provider contends that the Intermediary's inclusion of Heaven Sent Nursing Services into a non-reimbursable cost center of the Provider is completely without merit. The two agencies are separate corporations, have separate and distinct office locations as well as separate payrolls, staff, banking accounts and computer systems.

With respect to the owner/administrator, compensation was paid for work performed for the Provider as well as for work performed for the private agency. Contemporaneous time sheets were submitted to show that the owner/adminstrator worked full time for the Provider. Had the administrator not been compensated by the private duty agency, a presumption could have been raised that the Provider was attempting to inflate its reimbursable costs by shifting costs from the private duty agency to the Provider. However, this was not the case.

With regard to the Provider's controller, the Provider asserts that the controller worked on a full-time basis for the Provider and was never employed by the private duty agency. Testimony at the hearing by the Provider's administrator revealed that there were at least two and possibly three employees in the private duty agency that handled the private duty company's financial affairs. Furthermore, testimony at the hearing indicated that the controller's salary was comparable to that of other controllers in comparable companies within the same region. This reinforces the Provider's contention that Medicare reimbursements were soley for Medicare services and were not inflated to pay for nonreimbursable costs.

Finally, the Provider contends that the Intermediary erred in relying on the Board's decision in California Health Professionals, Inc., v. Blue Cross and Blue Shield Association/Wellmark Blue Cross and Blue Shield, PRRB Dec. No. 2000-D16, February 7, 2000, Medicare & Medicaid Guide (CCH) ¶ 80,392, decl'd rev. CMS

Admin., April 3, 2000 (California Health Professionals). In that case, the Board did not rule that the entirety of the second agency be placed in the first agency's non-reimbursable cost center. Instead, the Board ruled on the reclassification of specific salaries of individuals who worked for both agencies.

INTERMEDIARY'S CONTENTIONS:

It is the Intermediary's contention that the private duty costs must be included on the Medicare cost report to insure a proper allocation of costs through the step-down process. It points to CMS Pub. 15-1 § 2307, which states that:

> [t]he costs of a general service cost center need to be allocated to the costs centers receiving service from that cost center.

The Intermediary asserts that the private duty company received benefits from the general service cost centers of the Provider and that the two organizations are related as defined by 42 C.F.R. § 413.17(b) in that both are owned by the same individuals.[1]

The Intermediary points to the Board decision in California Health Professionals, supra. In that case, the intermediary adjusted the provider's direct costing by establishing a home office for allocation of shared services. The Board found there was no evidence to support the provider's request for a functional allocation, nor was there evidence to support a more sophisticated allocation methodology. The Intermediary contends that this is similar to the Provider's case wherein the Provider has attempted to exclude private-duty costs from the Medicare cost report and the Intermediary has adjusted to establish a non-reimbursable cost center for allocation of general service costs.

Issue No. 3 – Reclassification of the Community Education Coordinator's Salary to a Non-reimbursable Cost Center

FACTS:

The Provider claimed a salary of $14,387 for a Community Education Coordinator which was reflected in the A&G cost center in the Medicare cost report. Upon review, the Intermediary determined that the person in this position primarily conducted non-reimbursable activites, and the cost was reclassified to a non-reimbursable cost center.

PROVIDER'S CONTENTIONS:

[1] The Provider did not dispute that the two organizations were related.

The Provider contends that the work performed by its Community Education Coordinator fits within the parameters of CMS Pub. 15-1 § 2136.1, which states in part that:

> (c)osts of activities involving professional contacts with physicians, hospitals, public health agencies, nurses' associations, State and county medical societies, and similar groups and institutions, to apprise them of the availability of the provider's covered services are allowable. Similarly, reasonable production and distribution costs of informational materials to professional groups and associations, such as those listed above, are allowable if the materials primarily refer to the provider's operations or contain data on the number and types of patients served. Such materials should contribute to an understanding of the role and function of the facility as a provider of covered health care in the community.

The Provider maintains that the activities of its Community Education Coordinator, as stated in the job description, are the types of activities referenced in CMS Pub. 15-1 § 2136, and the costs are allowable. The job description states, in part:

> Nature of Job:
>
> Responsible for the education of the community and health professionals in an assigned geographic territory as it relates to home health care practices by visiting physicians, hospitals, insurance providers and administrators, social service agencies, and trust officers.

The Provider also points out that the time sheets covering the first month of the year were discussed at the Board hearing, and they verified that during this period the Coordinator worked on the Provider's brochure, designed forms, attended staff meetings, visited with physicians, designed surveys, designed a web page, and met with social service agency personnel, hospital personnel and nursing home personnel.

Time sheets submitted by Provider detail what the Community Education Coordinator was doing and whom he was seeing, and addenda were added to each time sheet to elaborate on activities. Such notations comport with the requirements of 42 C.F.R. § 413.24(c), which states that:

> [a]dequate cost information must be obtained from the provider's records to support payments made for services furnished to beneficiaries. The requirement of adequacy of data implies that the data be accurate and in sufficient detail to accomplish the purposes for which it is intended.

Finally, the Provider contends that the Board decisions cited by the Intermediary are without merit. In the case at hand, the Provider submitted contemporaneous time sheets and argues that the notations are sufficiently detailed to know what the Community Education Coordinator was doing. This is in contrast to those Board decisions cited by the Intermediary, wherein contemporaneous records were not maintained.

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that time spent on marketing and client service liaison activities is non-allowable as it is not related to patient care but is geared more toward increasing patient utilization. While the Intermediary agrees that time spent discussing patient care is an allowable function of the Community Education Coordinator, the Provider did not maintain time records to differentiate between the reimbursable and non-reimbursable activities. The Intermediary states that the Provider has not complied with the documentation requirements of the regulation at 42 C.F.R. § 413.20(a). It requires that providers:

> maintain sufficient financial records and statistical data for proper determination of costs payable under the program.

Id.

In support of its position, the Intermediary cites Harriet Holmes Health Care Services, Inc. v. Blue Cross and Blue Shield Association, Blue Cross and Blue Shield of Iowa, PRRB Dec. No. 97-D43, April 7, 1997, Medicare & Medicaid Guide (CCH) ¶ 45,169, decl'd rev., CMS Administrator, May 15, 1997, In Home Health Inc. v. Blue Cross and Blue Shield Association/Blue Cross and Blue Shield of Iowa and Illinois and Wisconsin, PRRB Dec. No. 96-D36, June 10, 1996, Medicare & Medicaid Guide (CCH) ¶ 44,477, aff'd in part, modified in part, CMS Admin., August 4, 1996, Medicare & Medicaid Guide (CCH) ¶ 44,594, rem'd, CMS Administrator, February 3, 1998, Medicare & Medicaid Guide (CCH), ¶ 46,141, and High Tech Home Health, Inc. v. Blue Cross and Blue Shield Association/Palmetto GBA, PRRB Dec. No. 2001-D12, February 21, 2001, Medicare & Medicaid Guide (CCH) ¶ 80,649, decl'd rev, CMS Admin., April 23, 2001.

The Intermediary asserts that the Provider failed to maintain time records in order to determine whether the activities were reimbursable. In the first two cases cited above, the providers failed to provide contemporaneous time records but and relied on the

job description solely or time records which the Board found to be untimely and insufficient because they were completed after the fact. The third case involved an Intake Coordinator and the lack of distinction on the time sheets between reimbursable and non-reimbursable activities.

Issue No. 4 – Disallowance of Administrator's Compensation

FACTS:

Provider claimed $114,174 in compensation for its owner/administrator on its cost report. Initially, the Intermediary reduced the administrator's reimbursable compensation to $58,151. The Intermediary later reopened the Medicare cost report, combined the administrator's compensation with that of her compensation from the private duty agency and then allocated the combined compensation to a shared cost center. The result was the administrator's reasonable compensation was deemed to be $61,993. However, only approximately $30,000 was deemed to be reimbursable because it was placed in a shared cost center with the private duty agency.

PROVIDER'S CONTENTIONS:

The Provider contends these amounts are significantly lower than even average compensation for home healthcare agencies in its region. In addition, for reasons delineated under Issue No. 2, the Provider contends that whatever compensation is deemed reasonable, it should not be reduced further by placing it in a shared cost center with the private duty agency.

Survey data from the Homecare Salary & Benefits Report from 1997-1998 showed that the median salary for an Executive Director/CEO of a home health care agency in Richmond, Virginia (the area in which Provider performs services) was $75,991 and the high salary was $89,482. The same survey data showed that the mid-point salary for the same position in Region 3 (South Atlantic Region) was $68,978 and the average maximum salary for the region was $83,324. In the same report, the value of the average fringe benefit package for managerial employees amounted to approximately 20% of the executive's salary. Combining the above figures, the total compensation would be the following:

Richmond median - $91,189, Richmond high - $107,378, Region 3 midpoint - $82,773, Region 3 average maximum - $99,989.

Additionally, the Provider pointed out in the hearing that in the 1999 cost report, the Intermediary adjusted administrator/owner compensation to $81,787, substantially more than the $61,993 allowed for 1997.

INTERMEDIARY'S CONTENTIONS:

The Provider claimed $114,174 in compensation for the services of its owner. Initially, the Intermediary determined that a reasonable compensation for the owner/administrator would be $58,151. This was further reduced by a factor of 38%,

which the Intermediary claimed represented the time the owner worked for Heaven Sent Services, a related organization. Accordingly, the initial disallowance was $77,984. Subsequently, the Intermediary reopened the Medicare cost report to modify its original adjustment. The salary and benefits of the two organizations were combined ($114,174 + $67,116) to reflect total compensation of $181,290. Of this amount the Intermediary determined reasonable compensation to be $61,993. The adjustments are summarized as follows:

	Orig. Adj.	Reopened Adj.	Variance
As-Filed Salary & Benefits	$114,174	$ 181,290	$67,116
Adjustment	$(77,984)	$(119,297)	$(41,313)
Adjusted Salary	$36,190	$61,993	$25,803

The Intermediary's determination of reasonable compensation was developed using the IBC Regression Analysis model. This model was developed from a survey which the Intermediary compiled based on unadjusted cost report data from Region 3 (Pennsylvania, West Virginia, Virginia, Maryland, and the District of Columbia) freestanding home health agencies with fiscal year ends of October 1, 1985 through September 30, 1986. The specific compensation analysis performed by the Intermediary on this Provider utilized an updated survey which captured data from fiscal years ending on September 30, 1992. Inflation factors were applied to the intervening years up through the adjusted December 31, 1997 Medicare cost report year.

To corroborate its analysis, the Intermediary utilized a compensation survey entitled Home Care Salary & Benefits Report 1997-1998. That survey reflected administrator compensation by agency type, revenue and location as follows:

Avg. CEO Comp. By Agency Type	Avg. CEO Comp. By Revenue	Avg. CEO Comp. By Location
$83,497	$71,766	$82,334

In summary, the Intermediary contends that the Provider's owner's compensation levels are substantially out of line with other agency administrators. In the absence of better data the Intermediary asserts that its regression analysis, updated with inflation factors, provides the best available evidence of reasonable compensation levels in this case.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board, after consideration of the Medicare law and guidelines, parties' contentions and evidence presented, finds and concludes as follows:

Issue No. 1 – Advertising

The Provider claimed $7,391 in advertising costs for a television spot which ran on two different television stations for approximately a two month period. The Provider stated that its primary purpose was to advise Medicare beneficiaries that they have a choice of providers and are not limited in the local area to only one agency. The Provider claimed that costs of this nature would be allowable under CMS Pub. 15-1 § 2136.1, which permits advertising of a public relations nature when the content presents a good public image and is related to patient care.

The Intermediary disallowed the claimed costs, citing CMS Pub. 15-1 § 2136.2, which defines unallowable advertising as the cost of advertising to the general public which seeks to increase patient utilization.

Faced with these competing guidelines, the Board reviewed the text of the Provider's advertisement and the audience to which it was targeted. Our review of the television spot does not indicate that the focus of the advertisement is patient solicitation in that there was no commentary regarding the Provider or the Provider's specific services. The text was directed solely to educating beneficiaries that the home healthcare benefit is available and that beneficiaries have a choice of providers. Accordingly, the Board concludes that the text fits squarely within the CMS guidelines set forth in CMS Pub. 15-1 § 2136.1.

Issue No. 2 – Non-Reimbursable Cost Center

It is undisputed that the Provider's owner also operated a non-Medicare private duty nursing company known as Heaven Sent Nursing. Because the two organizations were related, the Intermediary took the position that general service costs of the Provider should be distributed between the Provider and Heaven Sent Nursing. To accomplish this, the Intermediary moved the Heaven Sent costs onto the Provider's Medicare cost report by creating a non-reimbursable cost center. As a result, some of the Provider's Administrative and General costs were moved to the non-reimbursable cost center, thereby decreasing the Provider's Medicare reimbursement.

The Board finds that the Provider and Heaven Sent were separately incorporated, independently licensed, maintained separate checking accounts, and filed their own separate corporate tax returns. Also, for the year at issue, each entity had a separate

lease and a separate location. Time records indicated that the Provider's owner received a salary from each corporation.

The Intermediary's stated reasoning for combining the costs of the Provider with Heaven Sent is that expenses were shared between the two companies. Specifically,

the auditors referenced the Provider's owner drawing a salary from both entities, the CFO performing services for both entities and shared insurance policies.

The controlling regulations in this case state that:

> [t]he objective is that under the methods of determining costs, the costs with respect to individuals covered by the program will not be borne by individuals not so covered, and the costs with respect to individuals not so covered will not be borne by the program.
>
> . . .
>
> It is the intent of Medicare that payments to providers of services should be fair to the providers, to the contributors to the Medicare trust funds, and to other patients.

42 C.F.R. §§ 413.9 b(1) and (c)(1).

The Board finds and concludes that by applying the facts in this issue to the regulations, the Intermediary adjustment creating a non-reimbursable cost center was improper. Both documentation and testimony revealed that the Provider and Heaven Sent do not share facilities, patients, equipment, and, for the most part, employees. Although the owner/administrator was compensated by both entities, documentation indicated full time employment by the Provider. Testimony by Provider's owner and controller indicated that while some financial services were rendered by the controller for Heaven Sent, the amounts in question were *de minimis*. With regard to the Intermediary's reliance on there being a sole insurance policy, testimony revealed that one policy was obtained to take advantage of discounts available by obtaining a bundled policy. The Board notes that the Provider attempted to achieve cost savings which benefited the Medicare program by allocating the cost between Medicare and Heaven Sent. Similarly, testimony regarding the Intermediary's finding Heaven Sent storage boxes on the Provider's premises revealed that the boxes contained insurance policies that were sent to the Provider temporarily to assist in the Intermediary's audit of the insurance expense account.

The Board also notes that the issue of shared expenses was raised by the former Intermediary in a prior year. However, no adjustment was made. Based on all of the

above, the Board concludes that it is not appropriate to establish a non-reimbursable cost center in circumstances where shared costs are found to be immaterial.

Issue No. 3 – Classification of Community Education Coordinator Salary to a Non-Reimbursable Cost Center

The Intermediary reclassified the Community Education Coordinator's salary ($14,387 for a six-month period) to a non-reimbursable cost center on the grounds that the job description included activities that were geared toward increasing patient utilization. The Intermediary claimed that in its review of the time records, it could not distinguish between reimbursable and non-reimbursable activity.

The Board notes that the regulation at 42 C.F.R. § 413.20(a) requires that providers "maintain sufficient financial records and statistical data for proper determination of costs payable under the program."

Evidence in the record appeared to document the total time expended. However, notations as to specific activity were often unclear. The Provider's owner did attempt to interpret the notations during her testimony at the hearing. Specifically, she proffered that the notations were sufficient, in her estimation, to conclude that the Coordinator's efforts were geared toward community education.

While this testimony appears to support some reimbursable activity, it is not possible for the Board to quantify any particular dollar amount. Therefore, the Board finds that the documentation in the record does not rise to the level required by the Medicare regulation to support the claimed cost. Accordingly, the Board finds that an adjustment is warranted. Under normal cost finding procedures, the non-reimbursable cost center is established under CMS Pub. 15-1 § 2328 so that it may absorb all related overhead costs associated with the non-allowable costs. In this case, the coordinator was only employed for a six-month period or less during the year. As such, related overhead costs for office space, etc. would be minimal. Considering the immaterial overhead factor and Intermediary testimony that an alternative methodology would be to just exclude the unallowable cost from the Medicare cost report via an A-5 offset, the Board finds the latter approach to be the appropriate adjustment methodology.

Issue No. 4 – Administrator's Compensation Adjustment

The Provider claimed $114,174 in compensation for its owner. Initially, the Intermediary disallowed $77,984 as excessive compensation. However, the Intermediary later reopened the cost report, combined the administrator's compensation with her compensation from Heaven Sent and then allocated the combined compensation to a shared cost center. The resulting reasonable compensation was determined by the Intermediary to be $61,993. However, only approximately $30,000

was reimbursable since the reasonable compensation was placed in a shared cost center with the private duty agency.

The Board notes that the Intermediary is obligated under the Medicare regulations and manual to develop information that can be used to evaluate reasonableness of executive compensation. The Intermediary is required to obtain information on compensation paid by comparable institutions in the same geographical area. In assessing

comparability, the Intermediary is to consider factors such as duties and responsibilities of owners, size and type of institution and its geographic location. A range of comparable institutions is to be established and used to determine reasonableness.

In the instant case, the Intermediary developed its reasonable compensation level based on a compensation analysis developed by Independence Blue Cross ("IBC"). That analysis was based on a survey of between 30 to 40 freestanding, Region 3 (PA, VA, WV, MD, and D.C.) home health agencies with fiscal years ending October 1, 1991 through September 30, 1992. Inflation factors were also used to adjust up to the Provider's December 31, 1997 Medicare cost report.

The Board finds that the Provider offered alternative data to support its position that the Intermediary's compensation was inappropriate. Data from the Homecare Salary & Benefits Report from 1997-1998 showed that the mid-point salary for the same position in Region 3 was $68,978. In the same report, the average fringe benefit package for managerial employees amounted to approximately 20% of salary.

The Board finds the Administrator's compensation is excessive but not to the extent determined by the Intermediary. The regulation at 42 C.F.R. § 413.9(c)(2) states in part that:

> [t]he 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.

The Board concludes that the most relevant part in the above regulation is the comparison of an institution's costs with like institutions in the same area. The Board finds that the best evidence in the record is the data from the Homecare Salary & Benefits Report in that it is the most comprehensive and more recent than the Intermediary's survey data. The Board finds that using the mid-point for Region 3 and applying the 20% fringe benefit factor produces a total allowable compensation of $82,774.

The Board also finds that the Intermediary's determination to combine the Administrator's compensation with that received from Heaven Sent and the placement thereof of certain amounts in a shared cost center is without merit, based on the reasons delineated in Issue 2, above.

DECISION AND ORDER:

Issue No. 1 – Advertising

The Provider's television advertisement meets the criteria of CMS Pub. 15-1 § 2136.1. Accordingly, the Intermediary's adjustment is reversed.

Issue No. 2 - Non-Reimbursable Cost Center

Documentation and testimony revealed that the purported shared expenses relied upon by the Intermediary to establish a non-reimbursable cost center were immaterial. As a result, the Provider's methodology for determining costs was in accordance with the Medicare regulation at 42 C.F.R. § 413.9. The Intermediary's adjustment is reversed.

Issue No. 3 - Classification of Community Education Coordinator Salary to a Non-Reimbursable Cost Center

The Intermediary's adjustment disallowing the Coordinator's salary for lack of documentation was proper and is affirmed as to the monetary amount. Given the immaterial amount of overhead associated with the adjustment, the Intermediary is directed to exclude the unallowable cost from the Medicare cost report via an offset on Worksheet A-5.

Issue No. 4 – Administrator's Compensation

The Intermediary's adjustment reducing the Administrator's compensation is affirmed in part. Reasonable compensation for the Administrator is $82,774. The Intermediary's adjustment methodology combining the Administrator's compensation with the compensation from a related entity and establishing a non-reimbursable cost center is improper and is reversed.

BOARD MEMBERS PARTICPATING:

Suzanne Cochran, Esquire
Henry C. Wessman, Esquire
Gary B. Blodgett, DDS
Martin W. Hoover, Jr., Esquire

Date: May 2, 2003

FOR THE BOARD

Suzanne Cochran
Chairperson