PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2006-D42

PROVIDER -
Logos Healthcare Rehabilitation, Inc.
Boone, NC

Provider No.: 34-6538

vs.

INTERMEDIARY -
BlueCross BlueShield Association/
Palmetto Government Benefits
Administrators

DATE OF RECORD HEARING -
June 10, 2005

Cost Reporting Period Ended -
December 31, 1993

CASE NO.: 00-3347

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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 to provide health insurance to the aged and disabled. 42 U.S.C. §§1395-1395cc. The Centers for Medicare and 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 out to insurance companies known as fiscal intermediaries. Fiscal intermediaries determine payment amounts due the providers

[1] Issue 13 was withdrawn by Provider.

under Medicare law and under interpretive guidelines published by CMS. 42 U.S.C. §1395(h), 42 C.F.R. §§413.20(b) and 413.24(b).

At the close of its fiscal year, a provider must submit a cost report to the fiscal intermediary showing the costs it incurred during the fiscal year and the proportion of those costs to be allocated to Medicare. 42 C.F.R. §413.20. The fiscal intermediary reviews the cost report to determine the total amount of Medicare reimbursement due the provider and issues the provider a Notice of Program Reimbursement (NPR). 42 C.F.R. §405.1803. A provider dissatisfied with the intermediary's final determination of total reimbursement may file an appeal with the Provider Reimbursement Review Board (Board) within 180 days of the issuance of the NPR. 42 U.S.C. §1395oo(a); 42 C.F.R. §405.1835.

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Logos Healthcare Rehabilitation, Inc. (the Provider) was a privately owned, for profit, outpatient rehabilitation facility located in Boone, North Carolina. The Provider was one of three Medicare-certified facilities in the PTK Management, Inc. (PTK) chain of healthcare facilities. The Provider furnished outpatient physical, speech, and occupational therapy services to Medicare patients in various nursing homes. The Provider claimed costs for its services on its fiscal year ended December 31, 1993 cost report and also included home office costs allocated from PTK.

The Provider terminated from the Medicare program on April 30, 1999. The Provider's fiscal intermediary at the time of its termination was Blue Cross Blue Shield of North Carolina.[2] The Intermediary entered into an inter-plan agreement with First Coast Service Options, Inc. (First Coast) to perform the outstanding audits on all Logos facilities. First Coast made the audit adjustments at issue in this case in a Notice of Program Reimbursement (NPR) issued on June 27, 2000. The Provider timely appealed the adjustments to the Board and has met the jurisdictional requirements of 42 C.F.R. §405.1831-405.1841. The amount of Medicare reimbursement for all issues is approximately $1,146,946. Provider Exhibit A.

The Board held a hearing for this case on November 7, 2001. Because of concerns raised at the hearing, the Board suspended the proceedings and agreed to the Provider's request to make its decision on this case on the written record. Tr. at 11. Because so many of the Intermediary's adjustments were due to lack of documentation and the Provider contended that a full review of its documentation had not occurred, the Board requested that the Intermediary perform additional audit work. The Board allowed the Provider to submit additional documentation. At the Board's request, the Intermediary reviewed the additional documentation and on January 30, 2003, submitted a report and proposed post-audit adjustments. Exhibit I-4.

[2] Currently, Cahaba Safeguard Administrators, LLC is the Program Safeguard Contractor and Palmetto Government Benefits Administrator is the Intermediary. All three entities will be referred to as the Intermediary.

To facilitate consideration of the case on the record, the Board asked the Intermediary to submit a supplemental position paper that addressed, for any costs disallowed after the re-audit: 1) why the audit adjustment was made; 2) what additional documentation the Provider submitted; and 3) why the additional documentation was not sufficient to reverse the adjustment. After receipt of the Intermediary's supplemental position paper, the Provider was permitted to submit a brief in response to the Intermediary's revised positions and to submit to the Board documentation necessary to support its position. The Intermediary submitted its supplemental position paper on March 30, 2005. The Provider did not submit anything further. The record hearing was held on June 10, 2005.

The Provider was represented by Thomas William Baker, Esquire, of Troutman Sanders LLP. The Intermediary was represented by Eileen Bradley, Esquire, and Bernard Talbert, Esquire, of Blue Cross Blue Shield Association.

Issue 1. Was the Intermediary's adjustment to disallow costs due to missing records proper?

FACTS:

The Provider filed its Medicare cost report for fiscal year ended December 31, 1993 with the Intermediary on March 31, 1994. The Intermediary notified the Provider, by letter dated March 17, 1999, that it had contracted with First Coast to perform the outstanding audits of the Provider's facility. Subsequently, First Coast requested documentation from the Provider, by letters dated March 22, 1999 and March 24, 1999, to support certain costs claimed on the cost report. Exhibit I-8. First Coast initially notified the Provider that the audit would commence April 6, 1999, but the Provider requested that the entrance conference be delayed. The audit commenced on May 3, 1999 and on April 28, 1999, the Intermediary suspended payments to the Provider. The Provider notified the Intermediary in a letter dated April 28, 1999 that it would cease all operations. In a letter from its attorney, the Provider indicated that it would make its financial information available to the auditors but would have no staff available to assist with the audit. First Coast conducted its audit work and made adjustments to remove costs that it determined were not adequately supported by documentation. The amount of Medicare reimbursement at issue is approximately $1,146,946.

PARTIES' CONTENTIONS:

The Provider asserts that the Intermediary does not have the authority to disallow costs due to missing records after a five-year retention of records period, that the Provider claims applies, has expired. The Provider cites CMS Publication 9, Section 444 and a similar provision embodied in the Skilled Nursing Facility Manual, CMS Publication 12, Section 545.1 which list the types of records that must be maintained for a period of five years after the month the cost report to which they apply is filed with the Intermediary. The Provider asserts that it filed its cost report on or before March 31, 1994 and that under the rule, the record only had to be kept until March 31, 1999. The Provider claims that the Intermediary was required to conduct its audit within the five-year period and

disagrees with the Intermediary that the March 17, 22 and 24, 1999 requests for documentation to support certain costs claimed on its cost report required the Provider to maintain its records beyond a five-year retention period. The Provider also contends that it was improper for the Intermediary to disallow any costs for lack of documentation after the five-year period.

The Intermediary responds that the Provider is required to maintain and furnish adequate financial and statistical information to support costs claimed on the cost report. The Provider was notified by letters dated March 17, 22 and 24, 1999, that an audit was being conducted and that documents to support costs claimed were required. The Intermediary maintains that it timely notified the Provider of the audit and requested the documentation to verify costs and statistical information; therefore, records should have been available and furnished to the Intermediary. The Provider's failure to supply that information is grounds to disallow costs under the regulation at 42 C.F.R. §§413.20 and 413.24.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

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

The requirement to retain adequate documentation is delineated at 42 C.F.R. §§413.20 and 413.24. The regulations do not specify any time period for the retention of records. The five-year retention period referred to in CMS Pub. 12, Section 545.1 pertains to skilled nursing facilities and is not applicable to this case. In addition, the five-year period retention requirement in CMS Pub. 9, Section 444(B) specifically refers to the retention of clinical records, whereas CMS Pub. 9, Section 444(D) indicates that the other health insurance records may be destroyed when no longer needed for title XVIII purposes. The Provider was notified by the Intermediary on March 17, 1999 and by First Coast on March 22 and 24, 1999, that its records were required in order to conduct an audit for the cost report filed on March 31, 1994. The Board finds that the Provider did not comply with the general principles of cost reimbursement that require a provider to maintain sufficient financial records and statistical data for the proper determination of costs payable under the program. 42 C.F.R. §413.20. In addition, the Board finds that such documentation must be maintained and capable of verification by qualified auditors as required under 42 C.F.R. §413.24. For these reasons, the Board finds that the Provider was required to retain its records to support its costs as reported on the Medicare cost report until such time as a final determination was made by its fiscal intermediary/program safety contractor.

Even if a five-year time period did apply, the Board finds that the Provider was notified prior to the end of five years that the audit would take place and that records would be needed. Therefore, the Board finds that the Provider was in no way prejudiced because, at the time of the notification, it should still have had the records necessary for the audit and could have immediately provided them to the Intermediary or, at the very least, have

retained them for the audit. The Board concludes that the Intermediary's disallowance due to lack of documentation was proper.

Issue 2. Did the Intermediary improperly reopen the cost report?

FACTS:

The Provider filed its Medicare cost report for FYE December 31, 1993 on March 31, 1994. The Intermediary issued its NPR for fiscal year 1993 on June 27, 2000.

PARTIES' CONTENTIONS:

The Provider asserts that because the Intermediary failed to issue an NPR within 12 months of the Provider's filing, the NPR is untimely under 42 C.F.R. §405.1835(c). According to the Provider, it follows that failure to issue a timely NPR results in the Provider's cost report, becoming the final determination for purposes of future appeals as of the date it was filed. CMS Pub. 15-1 §2905. The Provider contends that since the cost report became final upon the filing date, the Intermediary's June 27, 2000 NPR is a reopening beyond the three year limit provided by 42 C.F.R. §405.1885.

The Intermediary responds that the Provider's cost report for fiscal year ended December 31, 1993 was not reopened, nor was a notice of reopening sent to the Provider. The NPR issued on June 27, 2000 is the Intermediary's final determination pursuant to 42 C.F.R. §405.1885 and is not a revision or reopening of an earlier determination. The Intermediary disputes the Provider's contention that the failure to issue an NPR within the 12-month period following the filing of the as-filed cost report results in the as-filed cost report becoming the final determination.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

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

The Medicare regulations do not provide that a filed cost report automatically becomes a final intermediary determination if the intermediary does not issue an NPR within the 12-month period after it is filed. The regulations provide that the intermediary must issue its final determination within a reasonable time frame and that if the intermediary has not issued an NPR within a 12-month period, a provider is entitled to a hearing before the Board. 42 C.F.R. §§405.1803(a) and 405.1835(c). If the Provider's position was correct, there would be no need for a provision allowing a provider to appeal when the intermediary has not issued an NPR within 12 months. The Board finds that the Provider's December 31, 1993 as-filed cost report did not become an Intermediary final determination and that the Intermediary's June 27, 2000 NPR was the Intermediary's final determination. Therefore, the Provider's argument that the cost report was reopened after the 3-year limitation is without merit.

Issue 3. Was the Intermediary's adjustment to physical therapy salaries proper?

FACTS:

The Intermediary disallowed the Provider's claimed physical therapy salary costs for lack of documentation. The Board requested that the Provider submit additional documentation and that the Intermediary review the documentation. After the review, the Intermediary continued to deny the costs. The amount of Medicare reimbursement at issue is approximately $410,413.

PARTIES' CONTENTIONS:

The Provider asserts that in order to audit salaries, the Intermediary is required to test the Provider's payroll system, use the employee's earning register to verify salaries and request and review appropriate documentation. The Provider claims that the Intermediary requested copies of W-2/1099's, contracts, employee job titles and the number of hours each employee worked in order to verify total paid salaries. However, the Intermediary disallowed the claimed physical therapy salaries, citing a lack of documentation. The Intermediary also claims that the Provider failed to provide requested W-2s, and that the salaries on the 1099 and 941 did not reconcile to salaries claimed on the as-filed cost report. The Provider asserts that the 1099 and 941 cannot be reconciled with the cost report because the cost report salaries are stated on the accrual basis of accounting, whereas the 1099 and 941 report salaries on the cash basis of accounting. The Provider contends that while not in the form of W-2s, it furnished to the Intermediary all information necessary to substantiate salaries.

The Intermediary's original adjustments were made due to lack of documentation. The Intermediary states that it reviewed the additional documentation submitted by the Provider which consisted of quarterly Federal Tax Return 941s but that no documentation such as payroll registers or W-2s were submitted. The Intermediary continues to claim that the documentation is insufficient to allow additional costs.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

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

The physical therapy salaries were accumulated at the Provider's home office, allocated to the Provider and claimed on the Provider's costs report. The Board finds that the Provider's failure to submit W-2s or 941s is not determinative. Rather, the real issue revolves around what services the employees provided and to which entity in the chain of providers. The Board finds that the Provider failed to submit payroll records, contracts or other verifiable documentation to prove that the costs were related to patient care and to support the basis for the allocation of costs from the home office to the Provider. The Provider merely presented a list of physical therapy employees at the home office but no documentation to indicate what services were provided or to which entity. Exhibit P-

3(b). The Board does not believe that the documentation requested by the Intermediary, i.e., W-2s and 941s would, in itself, necessarily be sufficient to support the allocation of these costs even if it had been furnished. Instead, the Provider should have provided a detailed account of the allowable services and associated hours provided by the physical therapy employees to each provider in support of the allocation. Absent this detailed documentation, the Intermediary's disallowance of these costs was proper.

Issue 4. Was the Intermediary's adjustments to the accrued 401(K) plan expenses, proper?

FACTS:

In a letter dated March 24, 1999, the Intermediary requested from the Provider a schedule of all accrued expenses and their liquidation, including the check number and payment, in order to select a sample to test the claimed accrued expenses. The Intermediary initially denied these cost due to a lack of supporting documentation. The Intermediary reviewed the new documentation submitted by the Provider in support of the accrued 401(k) plan expenses but did not change its original adjustment. The amount of Medicare reimbursement at issue for accrued 401(k) plan expenses is approximately $6,636.

PARTIES' CONTENTIONS:

The Provider claims that it submitted a page from its general ledger which supports the method of liquidation for accrued 401(k) plan expenses at issue.[3] The Provider states that the bank statements, including the cancelled checks, were available in the field for the Intermediary to review. The Provider asserts that the Intermediary did not review these records in the field and penalized the Provider for not mailing them to the Intermediary's office.

The Intermediary initially disallowed the accrued 401(k) plan expenses due to lack of supporting documentation. Additional documentation subsequently submitted by the Provider consisted of a 401(k) plan matching schedule which identified the employee's contributions and the company match, but the Provider did not include any account numbers and did not explain the accrual. Based on the submitted information, the Intermediary disallowed the accrued 401(k) plan expenses.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

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

The accrued expenses at issue were accumulated on the books of the home office and allocated to the Provider. In the initial audit, the Provider merely submitted a copy of its general ledger. There was no evidence presented to prove that the accrual was liquidated. On reaudit, the Provider submitted a 401(k) plan matching schedule that

[3] Exhibit P-4(b).

identified employee contributions and the company match but did not explain the accruals. Based on the record, the Board does not find any evidence to demonstrate how accrued 401(k) plan expenses were allocated to the Provider and liquidated. The record does not contain copies of the journal entries showing the manner in which costs were allocated to the Provider or copies of cancelled checks to prove that the costs were liquidated.

The Board finds the Intermediary's adjustment was proper because there is no evidence to support the basis of the allocation of these costs to the Provider and their liquidation.

Issue 5. Was the Intermediary's adjustment to the accrued payroll taxes proper?

FACTS:

In a letter dated March 24, 1999, the Intermediary requested from the Provider a schedule of all accrued expenses and their liquidation, including the check number and payment, in order to select a sample to test the claimed accrued expenses. The Intermediary initially denied these costs due to a lack of supporting documentation. The Provider did not submit any additional information for the Intermediary's review; consequently, the Intermediary did not change its original adjustment. The amount of Medicare reimbursement at issue for payroll tax expense is approximately $6,972.

PARTIES' CONTENTIONS:

The Provider claims that it submitted a page from its general ledger which supports the method of liquidation of accrued payroll tax expense at issue. The Provider states that the bank statements, including the cancelled checks, were available in the field for the Intermediary to review. The Provider asserts that the Intermediary did not review these records in the field and penalized the Provider for not mailing them to the Intermediary's office.

The Intermediary initially disallowed the accrued payroll tax expense due to lack of supporting documentation. On reaudit, the Provider did not submit any additional supporting documentation for the Intermediary's review. Therefore, the Intermediary did not revise its original adjustment.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

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

The accrued expenses at issue were accumulated on the books of the home office and allocated to the Provider. In the initial audit, the Provider merely submitted a copy of its general ledger. There was no evidence presented to prove that the accrual was liquidated. On reaudit, the provider did not submit any additional evidence to prove that the accruals were liquidated. Based on the record, the Board does not find any evidence to

demonstrate how accrued payroll tax expenses were allocated to the Provider and liquidated. The record does not contain copies of the journal entries showing the manner in which costs were allocated to the Provider or copies of cancelled checks to prove that the costs were liquidated.

The Board finds the Intermediary's adjustment was proper because there is no evidence to support the basis of the allocation of these costs to the Provider and their liquidation.

Issue 6. Was the Intermediary's adjustment to the accrued profit sharing plan expenses proper?

FACTS:

In a letter dated March 24, 1999, the Intermediary requested from the Provider a schedule of all accrued profit sharing plan expenses and their liquidation, including the check number and payment, in order to select a sample to test the claimed accrued expenses. The Intermediary initially denied these costs due to lack of supporting documentation. Although the Provider submitted additional documentation for the reaudit, the Intermediary did not change its original adjustment. The amount of Medicare reimbursement at issue for accrued profit sharing plan expenses is approximately $30,173.

PARTIES' CONTENTIONS:

The Provider claims that it submitted a page from its general ledger which supports the method of liquidation for accrued profit sharing plan expense at issue.[4] The Provider states that the bank statements, including the canceled checks, were available in the field for the Intermediary to review. The Provider asserts that the Intermediary did not review these records in the field and penalized the Provider for not mailing them to the Intermediary's office. In addition, the Provider contends that the Intermediary erroneously disallowed $30,173 when the general ledger reported only $21,092.[5]

The Intermediary initially disallowed the accrued profit sharing plan expense due to lack of supporting documentation. Additional documentation subsequently submitted by the Provider consisted of a profit sharing plan schedule which identified the profit distribution by employee.[6] However, the provider did not submit a calculation or an explanation to support the accrual on its liquidation. Therefore, the Intermediary disallowed the cost.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

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

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[4] Exhibit P-6(b).
[5] Exhibit P-6(b).
[6] Exhibit I-14 pages 1-5.

The accrued expenses at issue were accumulated on the books of the home office and allocated to the Provider. In the initial audit, the Provider merely submitted a copy of its general ledger, and no evidence was presented to prove that the accrual was liquidated. On reaudit, the Provider submitted a profit sharing plan schedule that identified profit distribution by employee but did not explain the accruals. Based on the record, the Board does not find any evidence of how accrued profit sharing plan expenses were allocated to the Provider and liquidated. The record does not contain copies of the journal entries showing the manner in which costs were allocated to the Provider or copies of cancelled checks to prove that the costs were liquidated.

The Board finds the Intermediary's adjustment was proper because there is no evidence to support the basis of the allocation of these costs to the Provider and their liquidation. The Board however, agrees with the Provider that the Intermediary erred in the amount of the adjustment and finds that Intermediary's adjustment should be modified to the amount on the Provider's general ledger and cost report.

Issue 7. Were the Intermediary's adjustments to accrued FICA and Federal withholding proper?

FACTS:

In a letter dated March 24, 1999, the Intermediary requested from the Provider a schedule of all accrued expenses and their liquidation, including the check number and payment, in order to select a sample to test the claimed accrued expenses. The Intermediary initially denied these costs due to a lack of supporting documentation and the Provider submitted additional schedules to support the accrual; however, the Intermediary did not modify its original adjustment. The amount of Medicare reimbursement at issue for accrued FICA and federal withholding tax expense is approximately $10,174.

PARTIES' CONTENTIONS:

The Provider claims that it submitted a page from its general ledger which supports the method of liquidation of the accrued FICA and federal withholding tax expenses at issue. The Provider states that the bank statements, including the cancelled checks, were available in the field for the Intermediary to review. The Provider asserts that the Intermediary did not review these records in the field and penalized the Provider for not mailing them to the Intermediary's office.

The Intermediary initially disallowed the accrued FICA and federal withholding tax expense due to lack of supporting documentation. On reaudit, the Provider submitted various schedules that were still considered inadequate to support the amount or basis of the accruals; the Intermediary did not modify its adjustment.[7]

[7] Exhibit I-14 pages 6-24.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

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

The accrued expenses at issue were accumulated on the books of the home office and allocated to the Provider. In the initial audit, the Provider merely submitted a copy of its general ledger. There was no evidence presented to prove that the accrual was liquidated. On reaudit, the Intermediary considered the additional documentation submitted by the Provider inadequate to support how the accrued FICA and Federal withholding tax expenses were allocated and liquidated. Based on the record, the Board does not find any convincing evidence, such as copies of journal entries showing the manner in which costs were allocated to the Provider or copies of cancelled checks, to prove that the costs were liquidated.

The Board finds the Intermediary's adjustment was proper because there is no evidence to support the basis of the allocation of these costs to the Provider and their liquidation.

Issue 8. Was the Intermediary's adjustment to health insurance costs paid on behalf of physical therapists proper?

FACTS:

The costs of health insurance related to physical therapists were accumulated on the home office cost report and allocated to the Provider. The Intermediary requested a schedule of all accrued expenses and their liquidation, including the check numbers and dates paid. The Intermediary initially denied these costs as employee benefits related to disallowed physical therapist salaries. After reviewing additional documentation submitted by the Provider, the Intermediary continued to deny the costs because the documentation did not support the basis for the allocation. The amount of Medicare reimbursement at issue is approximately $38,674.

PARTIES' CONTENTIONS:

The Provider claims that these costs were disallowed because salaries were disallowed, but that there is no connection between the salaries and the health insurance costs. Moreover, the Provider states that the insurance policies and invoices were available at its site, but the Intermediary chose not to look at them.

The Intermediary indicates that it initially removed these costs as employee benefits related to physical therapist salaries which were disallowed due to lack of supporting documentation. The Intermediary notes that the Provider did supply additional documentation for review which consisted solely of insurance schedules prepared by the Provider,[8] but the amounts claimed could not be traced to the general ledger. The Intermediary indicates that these costs were allocated to the providers in the chain from

[8] I-14 pages 25-28.

the home office cost statement through journal entries, but the Provider did not furnish any support for the journal entries. Without additional supporting documentation, the Intermediary continued to disallow these costs.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

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

Based on the record provided by the Intermediary and Provider, there is no evidence to support the allocation of accrued employee benefits for health insurance related to physical therapist salaries to a particular provider. Although the Intermediary based its decision on the denial of physical therapist salary costs, the Board finds that the more serious deficiency is the lack of information to support the accrual and allocation of these costs to this Provider. In addition, there are no copies of policies and invoices to prove that the costs were incurred. The Board finds that the Intermediary adjustments were proper because there is no document to support the basis for allocating these costs from the home office to the Provider. The Provider was also unable to demonstrate that employees for whom health insurance benefits were claimed were actually the Provider's employees.

Issue 9. Was the Intermediary's adjustment to contract physical therapy and Quality Assurance (QA) consultant expenses proper?

FACTS:

The costs of contract physical therapy and QA consulting were accumulated on the home office cost statement and allocated to the Provider. The Intermediary requested the contractor's name, actual services rendered, actual payments and accruals, if any, copies of 1099s, contracts, contractor logs including hours worked and whether the services were rendered on-site or off-site and the rates of services. The Intermediary initially denied these costs due to lack of documentation. After reviewing additional documentation submitted by the Provider, the Intermediary continued to deny the costs because the documentation did not support the basis for the allocation. The amount of Medicare reimbursement at issue is approximately $53,631.

PARTIES' CONTENTIONS:

The Provider states that an analysis of contract physical therapy services was provided to the Intermediary. Exhibit P-9(b). The Provider notes that the general ledger balance for this account was $90,828. Invoices provided to the Intermediary indicate that $53,631 was paid to a contractor for quality assurance services. The Provider asserts that this is a cost related to physical therapy that is allowable by the Medicare program; therefore, the adjustment should be reversed.

The Intermediary states that it initially removed the costs for physical therapy and quality assurance consultant expenses due to lack of supporting documentation but notes that the Provider did furnish additional documentation for review consisting of therapist billing summaries, physical therapist logs and check copies. Exhibit I-14 at 30-38. The Intermediary claims that the invoices submitted by the Provider were in disarray. The Intermediary determined that the activity posting to this account was entirely by journal entry with the exception of one invoice for $9,800. The Provider did not submit copies of the journal entries or documentation demonstrating how the costs were allocated to the Provider. The Intermediary did not allow any additional contracted physical therapy services costs; however, the Provider was able to document an additional 44 hours of physical therapy services, and the Intermediary allowed these hours on Worksheet A-8-3.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

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

Based on the record provided by the Intermediary and Provider, the evidence is insufficient to support contracted services for physical therapist quality assurance. Although the Provider did provide some evidence that quality assurance services were performed, the Board did not find any copies of the journal entries or other documentation to support the accrual and allocation of these costs to the Provider. The Board finds that the Intermediary's adjustment was proper because there is no documentation to support the basis for allocating these costs to the Provider.

Issue 10. Was the Intermediary's adjustment to contracted occupational therapy proper?

FACTS:

The costs of contract services for occupational services were accumulated on the home office cost statement and allocated to the Provider. The Intermediary initially denied these costs due to lack of documentation. After review of the additional documentation supplied by the Provider, the Intermediary continued to deny the costs because the Provider did not support the basis for the allocation. The amount of Medicare reimbursement at issue is approximately $360,406.

PARTIES' CONTENTIONS:

The Provider asserts that the Intermediary never requested any documentation to support these costs. The Provider states that the occupational therapists were employed by the home office and their cost was allocated to the Provider based on time spent by the therapists in the various nursing homes. The Provider claims that journal entries demonstrating the allocation were furnished to the Intermediary. Exhibit P-10(c). The Provider argues that the method of allocation was the same in 1992 and had been reviewed and accepted by the Intermediary. In addition, the Provider claims that the

Intermediary erroneously disallowed $22,782 because it could not reconcile the Occupational Therapy cost center costs with the general ledger expense for occupational therapy. However, the Provider is able to reconcile these costs. Exhibit P-102. Therefore, this adjustment should be reversed. The Provider also maintains that it erroneously understated its occupational therapy costs by $31,726 in the as-filed cost report and requests that the Intermediary make an adjustment to correct this error. Finally, the Provider asserts that the Intermediary improperly applied a limit of $41.03 per hour to the cost of occupational therapy salaries based on a May 5, 1995 HCFA letter.

The Intermediary indicates that it initially removed the costs of contract services for occupational therapy due to lack of supporting documentation but that the Provider furnished additional documentation for its review consisting of invoices and check copies. The Intermediary indicates it that had already reviewed these items and that no new documentation was submitted. Because there was no new information, the Intermediary did not allow any contracted occupational therapy services cost.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

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

The evidence in the record is insufficient to support the cost claimed for contracted services for occupational therapy. The Board notes that while the Provider claims that its cost allocation was allowed in fiscal 1992, the circumstances in fiscal year 1992 do not relieve the Provider of its obligation to support its allocation in the current fiscal year. The Board further notes that the Provider submitted a document that it claims shows the allocated cost based on a monthly computation. Exhibit P-10(d). However, the Provider has not explained how these figures support its argument. The Board did not find any documentation to support the Provider's claim that its costs were understated by $31,726. Neither did the Board find any copies of journal entries or documentation to support the accrual and allocation of these costs to the Provider. The Board finds that there is no documentation to support the basis upon which the home office allocated occupational therapy costs to the Provider; therefore, but for correction of the errors the Board identified in the amount of the Intermediary's adjustments, as discussed below, the Board finds that the Intermediary's adjustment to remove these costs was proper.

The Board noted the following errors in the Intermediary's adjustments. First, the Intermediary applied a salary equivalency limit of $41.03 per hour for occupational therapy services. Exhibit P-10(a), at 1. The Board finds that there were no salary equivalency guidelines for occupation speech therapy services during the year at issue, and that the rate of $50 per hour claimed by the Provider; Id. at 2, must be allowed unless proven to be substantially out line. 42 C.F.R. §413.9(c)(2).[9] Therefore, the Intermediary's adjustment is hereby modified to allow additional costs of $5,160.

[9] The $5,160 disallowed by the Intermediary should be added back as allowable cost, as there is no basis to use $41.03 instead of $50 as claimed by the Provider.

Second, the Intermediary disallowed $360,406 of the total $366,146 claimed by the Provider for occupational therapy on the cost report. Some costs were allowed for documented travel expenses. The Board notes, however, that the $366,148 figure included $22,784 in costs related to contract OT services other than the contract services that were disallowed. Exhibit P-102 at 3. Specifically, these costs included minor equipment - $130; other (dues) - $1,735; recruiting - $1,108; supplies - $16,266 and travel - $3,583. There is no evidence that the Intermediary requested documentation for and reviewed these costs, except for travel costs, for which it found documentation and allowed $582. Therefore, the Intermediary's adjustment is hereby modified to allow $19,199 in additional occupational therapy costs.

Issue 11. Was the Intermediary's adjustment to contracted speech therapy proper?

FACTS:

The Provider claimed $165,014 for the cost of contract services for speech therapy. The speech therapy costs were accumulated on the home office cost statement and allocated to the Provider. The Intermediary could not reconcile the amount on the general ledger of $163,027 for speech therapy contract services with the cost report and, therefore, reduced the amount allowed by $1,987. Exhibit P-11(a) at 1. The Intermediary also reduced the amount claimed by $16,919 to limit the cost of speech therapy services to an allowable hourly rate of $41.03. Id. at 2. The Intermediary reviewed and allowed $123 for travel costs. In addition to these adjustments, the Intermediary denied the remaining speech therapy costs due to lack of documentation. After its review of the additional documentation furnished by the Provider, the Intermediary continued to deny most of the cost because the Provider did not support the basis for its claim. The Intermediary was able to verify one additional invoice and proposed a positive adjustment of $2,832.50. The amount of Medicare reimbursement at issue is approximately $147,972.

PARTIES' CONTENTIONS:

The Provider asserts that the Intermediary never requested any documentation to support these costs. The Provider states that the speech therapists were employed by the home office and their cost was allocated to the Provider based on time spent by the therapist in the various nursing homes. The Provider claims that journal entries demonstrating the allocation were furnished to the Intermediary. Exhibit P-11(c). The Provider argues that the method of allocation was the same in 1992 and been reviewed and accepted by the Intermediary. In addition, the Provider claims that the Intermediary erroneously disallowed $1,987 because it could not reconcile the Speech Therapy cost center costs will the general ledger expense for Speech Therapy. However, the Provider is able to reconcile these costs. Exhibit P-102. Therefore, this adjustment should be reversed. Finally, the Provider asserts that the Intermediary erroneously applied an hourly limit of $41.03 per hour to the cost of speech therapy salaries based on a May 5, 1995 HCFA letter.

The Intermediary indicates that it initially removed the costs of contract services for speech therapy due to lack of supporting documentation but the Provider furnished additional documentation for review consisting of monthly billing summaries, service logs, invoice copies and check copies. The Intermediary states that it could not verify the costs in the general ledger to ensure the costs were not duplicated through the flow of costs from the home office cost statement, but it was able to verify one invoice in the amount of $2,832.50 and proposed a revised adjustment. Exhibit I-6 at 17-18.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

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

The Board finds that there is insufficient evidence in the record to support the cost of contracted services for speech therapy. The Board notes that while the Provider claims that its cost allocation was allowed in fiscal 1992, the circumstances in fiscal year 1992 do not relieve the Provider of its obligation to support its allocation in the current fiscal year. The Board further notes that the Provider submitted a document that it claims shows the allocated cost based on a monthly computation. Exhibit P-11(d).

The Boards finds that there is no documentation to support the basis upon which the home office allocated speech therapy costs to the Provider; therefore, but for correction of the errors the Board identified in the amount of the Intermediary's adjustments, as discussed below, the Board finds that the Intermediary's adjustment to remove these costs was proper.

The Board noted the following errors in the Intermediary's adjustments: First, the Intermediary applied a salary equivalency limit of $41.03 per hour for speech therapy services. Exhibit P-11(a) at 1. The Board finds that the there were no salary equivalency guidelines for speech therapy services during the year at issue, and that the rate of $50 per hour claimed by the Provider, Id. at 2, must be allowed unless proven to be substantially out of line. 42 C.F.R. §413.9(c)(2). Therefore, the Intermediary's adjustment is hereby modified to allow additional costs of $16,919.

Second, the Board notes that the amount claimed for speech therapy on the cost report included the cost of contract services of $163,026 as well as other costs totaling $1,988; Other - $80; Recruiting - $625 and Travel - $1,283. Exhibit P-102 at 2 and 4. There is no evidence that the Intermediary requested documentation for and reviewed these costs, except for travel costs, of which $123 was allowed. Exhibit P-11(a). Therefore, the Intermediary's adjustment is hereby modified to allow $705 in additional speech therapy costs.

Issue 12. Was the Intermediary's adjustment to auto expense proper?

FACTS:

The Provider claimed auto expenses which the Intermediary initially denied due to lack of documentation. After reviewing the additional documentation supplied by the Provider, the Intermediary continued to deny the costs because none of the costs could be traced to the general ledger, and the documentation was still insufficient to determine whether the costs were related the patient care. Intermediary's Supplemental Position Paper. Exhibit I-6 at 5. The amount of Medicare reimbursement at issue is approximately $7,989.

PARTIES' CONTENTIONS:

The Provider asserts that it furnished a copy of the general ledger providing a detailed explanation of the nature of the expense to the Intermediary. The Provider claims that the documentation supporting the cost was available at its facilities but the Intermediary did not audit it. Instead the Intermediary insisted that the Provider copy all invoices and documentation and mail them to its office in Miami. The Provider asserts that this was an unreasonable request.

The Intermediary indicates that it initially removed the auto expense due to lack of supporting documentation. The Intermediary notes that the Provider furnished additional documentation for review consisting of invoice copies and expense reports. The Intermediary claims that none of that documentation could be traced to the general ledger, and it was insufficient to determine whether the costs were related to patient care. Therefore, the Intermediary did not propose any change to its original adjustment. Exhibit I-6 at 5.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

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

There was no evidence in the record to determine whether the costs claimed were related to patient care or that tied the invoices to the general ledger. The Board finds that without proper documentation, the Provider's claim for auto expense is not supported, and the Intermediary's adjustment was proper.

Issue 13. Was the Intermediary's adjustment to auto lease expense proper?

This issue was withdrawn by the Provider.

Issue 14. Was the Intermediary's adjustment to administrative recruiting proper?

FACTS:

The Provider claimed administrative recruiting costs which the Intermediary initially denied due to lack of documentation. After its review of additional documentation supplied by the Provider, the Intermediary allowed additional costs that could be traced to

the general ledger. Intermediary's Supplemental Position Paper, Exhibit I-6 at 5. The amount of Medicare reimbursement at issue is approximately $46,031.

PARTIES' CONTENTIONS:

The Provider claims that it furnished invoices and contracts to the Intermediary to support the claimed recruiting cost. The Provider indicates that the Intermediary's reasons for its denial were not clear, and that these costs should not be disallowed until the Intermediary provides more information concerning the reasons for its denial.

The Intermediary indicates that it initially removed administrative recruiting expenses due to lack of supporting documentation but the Provider furnished documentation for its review consisting of invoice copies and physical therapy contracts. The Intermediary states that individual invoices were traced to the general ledger to ensure they were not posted to the home office or another facility in the chain. Invoices that did not trace to the general ledger were not allowed. The Intermediary allowed $3,000 in administrative recruiting costs and proposed a revision to its original adjustment. Exhibit I-6 at 3-4.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

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

There is no evidence in the record to determine whether the costs claimed by the Provider ties the invoices to the general ledger. The Board finds that without proper documentation the Provider's claim for recruiting costs is not supported and the Intermediary's revision to its original adjustment is proper.

Issue 15. Was the Intermediary's adjustment to telephone expenses proper?

FACTS:

The Provider claimed telephone expenses which the Intermediary initially denied due to lack of documentation. After its review of additional documentation supplied by the Provider, the Intermediary allowed additional costs that could be traced to the general ledger. The amount of Medicare reimbursement at issue is approximately $25,358.

PARTIES' CONTENTIONS:

The Provider claims that the Intermediary disallowed its cost because it did not provide a copy of all the telephone bills. The Provider indicated that the records were available at its facility and the Intermediary did not review them. Instead, the Intermediary required that the Provider copy and mail all its records to the Intermediary. The Provider asserts that this was unreasonable.

The Intermediary indicates that it initially disallowed telephone expenses due to lack of supporting documentation but the Provider furnished additional documentation for the Intermediary's review consisting of invoice copies. The Intermediary states that it allowed all invoices that could be traced to the general ledger. Based on its additional audit work, the Intermediary allowed $9,325 in telephone expense and proposed a revision to its original adjustment. Exhibit I-6 at 31-36.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

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

There was no evidence in the record to determine whether the costs claimed by the Provider tied the invoices to the general ledger. The Board finds that without proper documentation, the Provider's claim for telephone expense is not supported and the Intermediary's revision to its original adjustment is proper.

Issue 16 Was the Intermediary's adjustment to accounting expense proper?

FACTS:

The Provider claimed accounting expenses which the Intermediary initially denied due to lack of documentation. After its review of the additional documentation supplied by the Provider, the Intermediary did not allow any additional costs because the documentation furnished could not be traced to the general ledger. The amount of Medicare reimbursement at issue is approximately $21,407.

PARTIES' CONTENTIONS:

The Provider claims that the Intermediary disallowed its accounting costs because it did not furnish copies of its accounting invoices. The Provider indicates that it furnished invoices totaling $20,175, or 50.52 percent of its total transactions. The Provider notes that the Intermediary determined that $1,650, or 8.18 percent of the costs were not allowable. The Provider claims that it should not have to produce 100 percent of its invoices, and that the Intermediary should have based its denial on the percentage of costs disallowed. In addition, the Provider claims that the $1,650 disallowed related to an embezzlement investigation, and that if insurance related to employee theft is allowed, so should costs associated with an investigation related to employee theft. CMS Pub. 15-1 §2160.3.

The Intermediary indicates that it initially disallowed accounting expenses due to lack of supporting documentation but the Provider furnished additional documentation for review consisting of invoice copies. The Intermediary states that it allowed all invoices that could be traced to the general ledger, but noted that only one new invoice was found, and it could not be traced to the general ledger. Based on its additional audit work the Intermediary did not allow any additional costs. Exhibit I-6 at 10-11.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

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

The Intermediary's insistence on 100 percent of invoices was not reasonable. The Provider submitted transaction invoices covering 50.52% of its total accounting costs to support its accounting expense. The Board also finds that the cost associated with the embezzlement investigation is a reasonable and customary expense incurred by providers and, therefore, the disallowance of $1,350 should be reversed. Exhibit P-16(a). The record does indicate that there was a $300 disallowance where the costs could not be linked to patient care. Id. The Board finds that a $300 disallowance out of $20,175 of documented costs is immaterial, and that no disallowance for accounting expenses should be made. The Board finds that the Intermediary should have allowed all accounting costs based on the percentage of allowable accounting invoices it was provided. Therefore, the Intermediary's adjustment is reversed.

Issue 17. Was the Intermediary's adjustment to occupational therapy dues proper?

FACTS:

The Provider claimed administrative dues which the Intermediary initially denied these costs due to lack of documentation. After its review of additional documentation supplied by the Provider, the Intermediary did not find sufficient documentation to allow any additional costs. The amount of Medicare reimbursement at issue is approximately $1,735.

PARTIES' CONTENTIONS:

The Provider claims that the Intermediary disallowed costs associated with its membership in AOTA because it did not know what these costs represented. The Provider indicates that AOTA stands for "American Occupational Therapist Association," that the cost was for membership fees for Provider's employees, and that this is an allowable cost. CMS Pub. 15-1 §2138.1.

The Intermediary indicates that it initially disallowed costs related to AOTA due to lack of documentation but that the Provider subsequently furnished documentation that consisted solely of an application for an occupational therapy conference. No other documentation such as invoices or check copies was submitted. In addition, the amounts listed could not be traced to the general ledger. Based on its additional audit work the Intermediary did not allow any additional costs. Exhibit I-6 at 7.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

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

There is no documentation in the record to support the Provider's claim that these costs were for memberships in a professional organization or that they were paid for persons who were employed by the Provider. Without any documentation, the Board finds that the Intermediary's adjustment disallowing these costs was proper.

Issue 18. Was the Intermediary's adjustment to administrative dues proper?

FACTS:

The Provider claimed costs for administrative dues which the Intermediary initially denied due to lack of documentation. After its review of additional documentation supplied by the Provider, the Intermediary did not find sufficient documentation to allow any additional costs. The amount of Medicare reimbursement at issue is approximately $6,701.

PARTIES' CONTENTIONS:

The Provider claims that it furnished the Intermediary with invoices for $1,294 or 19.31 percent of these costs. The Provider claims that all of these costs are allowable expenses, and that it was not reasonable for the Intermediary to require the Provider to furnish 100 percent of invoices to allow these costs. CMS Pub. 15-1 §2138.1.

The Intermediary disallowed some costs related to administrative dues due to lack of documentation. The Intermediary notes that the Provider furnished invoice copies without any copies of checks reflecting payment. Based on its additional audit work, the Intermediary did not allow any additional costs. Exhibit I-6 at 8.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

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

The Provider only submitted invoices for 19 percent of its costs relating to administrative dues. The Intermediary allowed all costs for which invoices were submitted and disallowed the remaining costs claimed. The Board finds that the Provider did not submit a sufficiently large sample of invoices to support its request that all costs be allowed. Moreover, unlike accounting services, administrative dues are not a routine business expense. Without any additional documentation, the Board finds that the Intermediary's adjustment disallowing some of the administrative dues was proper.

Issue 19. Was the Intermediary's adjustment to nursing home rent expense proper?

FACTS:

The Provider rented space in nursing homes to deliver therapy services and claimed the costs on its cost report. The Intermediary initially denied most of these costs due to lack

of documentation. After its review of additional documentation supplied by the Provider, the Intermediary allowed additional costs where contracts were provided and costs claimed tied to the general ledger. The amount of Medicare reimbursement at issue is approximately $16,900.

PARTIES' CONTENTIONS:

The Provider asserts that the Intermediary was aware that most therapy companies rent space at nursing facilities for their equipment and to provide space for patient care. The Provider claims that this issue was reviewed by the Intermediary in 1992, and it was aware that most of the rental agreements were oral and had recommended that all new contracts and renewals contain a clause relating to rental expense. The Provider presented a contract with Bethesda Healthcare Facility that related to rental expense and showed how these costs were properly recorded in the general ledger. The Provider claims that all of these costs are allowable expenses and that the Intermediary has no basis to disallow these costs.

The Intermediary disallowed all nursing home rental costs except for the one facility where a rental contract was provided. The Intermediary notes that the Provider subsequently supplied lease agreements for two additional nursing facilities and that it proposed allowing an additional $5,500 in a revision to its original adjustment. Exhibit I-6 at 20-22.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

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

The Board notes that the Intermediary in its initial and subsequent reviews of the Provider's documentation allowed all nursing home rental expense for which the Provider had lease agreements and the expenses could be tied to the general ledger. There is no documentation in the record to support the Provider's claim for additional nursing home rental expense. The Board finds that the Intermediary's disallowance of nursing home expense for which there was no documentation was proper.

Issue 20. Was the Intermediary's adjustment to rent expense proper?

FACTS:

The Provider claimed rental expense for its offices which the Intermediary denied because payment was to a related party and cost of ownership information was not provided, some payments were determined to be a retainer fee, and other costs were not allowable due to an incomplete record of contracts or costs that did not tie to the general ledger. Exhibit P-20(a). After its review of additional documentation supplied by the Provider, the Intermediary did not allow any additional costs for the same reasons as its

initial denial. Intermediary's Supplemental Position Paper, Exhibit I-6 at 23. The amount of Medicare reimbursement at issue is approximately $15,657.

PARTIES' CONTENTIONS:

The Provider presented a copy of its general ledger, Exhibit P-20(b), and indicates that costs disallowed by the Intermediary in its workpaper, Exhibit P-20(a), should be allowed. The Provider states that the Intermediary determined that rent paid to a related party, Blust Properties, should be an allowable cost but limited to operating costs of the related party. The Provider points out, however, that the entire costs were disallowed. The Provider also claims that payments to Dr. Garland Wampler were misposted to the rent account and actually represent a $75 per month fee for his role as Medical Director and, therefore, should be allowed. The Provider asserts that rental costs of $582 paid to Grandfather Mountain Storage is allowable because it was for temporary storage of its records. The Provider explains that for the first part of 1993 it rented one office condominium suite from Hasting & Co. for $425 per month, and that these costs had been allowed by the Intermediary. Later in the year, it rented two more office condominium suites for $900 per month, for a total of $1,325 per month. The Provider asserts that Hasting & Co. and Tracy Lamar were one and the same; therefore, the subsequent payment of $2,550 to Tracy Lamar should be allowed. Finally, the Provider asserts that after the building was subsequently sold to a Dr. Lowell Furman, the Provider rented more space for its clinic. Thus the payment of $10,900 to Dr. Furman should be permitted. The Provider indicates that the Intermediary toured the facility and information was available to substantiate these transactions.

The Intermediary disallowed some office lease expense due to lack of documentation but states that the Provider submitted additional documentation which consisted of lease agreements and check copies. The Intermediary claims that the information provided was not complete. In some instances, the check copies could not be traced to the general ledger. The Intermediary argues that the expense for Dr. Wampler was not supported and amounted to an unallowable retainer fee. The Intermediary claims that the expense for Blust Properties, a related party, had to be reduced to cost, but the Provider did not provide the necessary information to enable this to be done. Due to the lack of adequate documentation, the Intermediary did not propose a revision to its original disallowances.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

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

The Board notes that the only documentation in the record was a copy of the Provider's general ledger. There is no specific evidence to support the Provider's claims. There is no information concerning the costs incurred by the Provider's related party, no information to support the cost of Dr. Wampler, and no information to substantiate that the costs paid to either Tracy Lamar or Dr. Furman were related to lease agreements.

Without this information in the record, the Board finds that the Intermediary adjustments disallowing the costs due to lack of documentation were proper.

Issue 21. Was the Intermediary's adjustment to office equipment lease expense proper?

FACTS:

The Provider claimed rental payments for office equipment which the Intermediary initially denied due to lack of documentation. Exhibit P-21(a). Based on the additional information provided, the Intermediary allowed an additional $7,071 for office equipment lease expenses. The amount of Medicare reimbursement at issue is approximately $38,189.

PARTIES' CONTENTIONS:

The Provider presented a copy of its general ledger, Exhibit P-21(b), and indicates that the costs at issue were for office equipment. The Provider states that the Intermediary could have verified the accuracy of these accounts on-site during the audit but did not do so. Instead, the Intermediary requested that the information be copied and mailed to them. The Provider asserts that the costs were incurred, were accurately claimed and were program related and allowable costs.

The Intermediary initially disallowed the office equipment lease expenses due to lack of documentation. The Intermediary states that the Provider subsequently submitted additional documentation consisting of lease agreements and check copies, and items that were adequately supported and could be traced to the general ledger were allowed. Exhibit I-6 at 25-30.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

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

The Board notes that the only documentation in the record was a copy of the Provider's general ledger. The Board notes that the Intermediary subsequently allowed additional costs for which it received supporting documentation and could trace the costs to the general ledger. Without any additional documentation to support the Provider's claims, the Board finds that the Intermediary's denial of those costs due to lack of documentation is proper.

Issue 22. Was the Intermediary's adjustment to other charges – occupational, physical and speech therapy proper?

FACTS:

The Intermediary made adjustments to reconcile Medicare therapy charges per the as-filed cost report to the Provider Statistical and Reimbursement Report. Since total therapy charges come from the Provider's records and are not impacted by this reconciliation, decreases in Medicare charges precipitate an increase in "other charges."

Other charges usually represent denied claims for therapy services. After its review of additional documentation furnished by the Provider, the Intermediary did not revise its original adjustment. The amount of Medicare reimbursement at issue is approximately $59,000.

PARTIES' CONTENTIONS:

The Provider disagrees with the Intermediary's increase of the Provider's non-Medicare charges. The Provider claims that non-Medicare charges were not listed on the PS&R and that it maintained financial logs to record all charges. The Provider asserts that these logs were available to the Intermediary during the review and that the Intermediary did not make a written request for this information. The Provider contends that the adjustments were made without any basis and should be reversed.

The Intermediary made adjustments to reconcile the Medicare charges and other charges to agree with the PS&R and to reconcile to total charges. The Intermediary reiterated its offer to review any additional records produced by the Provider.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

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

The Board notes that the Intermediary offered to review the Provider's records to determine whether the adjustment for charges should be reversed. However, there is nothing in the record to indicate that the Provider made those records available to the Intermediary. In addition, the record does not contain the Provider's financial logs. Without any documentation to support the Provider's claim, the Board finds that the Intermediary's adjustments to reconcile the Medicare charges and other charges to agree with the PS&R were proper.

Issue 23. Were the Provider's requests for additional costs for depreciation, contracted occupational therapy services, recruiting-physical therapy, recruiting-administrative and accounting expenses proper?

FACTS:

The Provider did not claim the correct depreciation expense in its cost report, and due to an accounting error, did not include costs related to contract services, recruiting and

accounting. The Intermediary stated that the depreciation schedule prepared and approved by the Intermediary in previous years would be reviewed and the correct depreciation allowed. For unclaimed costs, the Intermediary suggested that the Provider request a reopening and submit adequate documentation to support the inclusion of additional costs. Intermediary Supplemental Position Paper at 22. The amount of Medicare reimbursement at issue is approximately $58,054.

PARTIES' CONTENTIONS:

The Provider claims that during the 1992 audit, which was completed in 1995, the Intermediary developed a depreciation schedule for the Provider. The Provider states this schedule was developed after it submitted cost reports for fiscal years 1993 through 1995. The Provider asserts that the Intermediary should have relied upon prior year audit workpapers and corrected the depreciation expense for the year under appeal. With respect to other additional costs for contract services, recruiting and accounting, the Provider claims that its accounting system is on a cash basis, and that at the end of the year it is converted to an accrual basis to meet Medicare regulations. In making the conversion, the Provider states that its mistakenly removed costs for contract services related to occupational therapy amounted to $31,726 and that costs for recruiting/physical therapy and recruiting/administrative and accounting were also understated. The Provider requests that the Intermediary include these additional costs in fiscal year 1993.

The Intermediary stated that the depreciation schedule prepared and approved by the Intermediary in previous years would be reviewed and the appropriate depreciation allowed. For unclaimed costs, the Intermediary asserts that it had not made adjustments for these items and, therefore, the Provider should have requested a reopening. The Intermediary claims that the Provider had submitted spreadsheets with information as support for inclusion of these costs, but that adequate supporting documentation would also have to be furnished.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

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

The Board notes that the Intermediary stated that it would review the previously approved depreciation schedule and allow the appropriate depreciation expenses. The Board remands this matter to the Intermediary to allow the appropriate depreciation expenses.

With respect to unclaimed costs, the Board agrees with the Intermediary that it did not make audit adjustments for these costs and that the Provider would need to request a reopening of the cost report in order to request that the additional costs be included in the cost report.

DECISIONS AND ORDERS:

Issue 1. Missing Records

The Board finds that the Provider was required to maintain its financial records for the audit. The Intermediary's disallowances for lack of documentation are affirmed.

Issue 2. Reopening

The Board finds that the Provider's December 31, 1993 cost report did not become a final determination and that the Intermediary's NPR did not constitute a late reopening of the Provider's cost report. The Intermediary's June 27, 2000 NPR is the Intermediary's final determination.

Issue 3. Physical Therapy Salaries

The Board finds that the Provider did not provide documentation to support the allocation of physical therapy salaries. The Intermediary's adjustment disallowing physical therapy salaries is affirmed.

Issue 4. 401(K) Plan

The Board finds that the Provider did not provide documentation to support the allocation of 401(k) plan expenses. The Intermediary's adjustment disallowing 401(k) plan expenses is affirmed.

Issue 5. Payroll Taxes

The Board finds that the Provider did not provide documentation to support the allocation of accrued payroll taxes to the Provider or that the accruals were liquidated. The Intermediary's adjustment disallowing payroll taxes is affirmed.

Issue 6. Profit Sharing Plan

The Board finds that the Provider did not provide sufficient documentation to support the allocation of profit sharing costs. The Board also finds that the Intermediary's adjustment incorrectly disallowed $30,173 versus the $21,092 claimed by the Provider. The Intermediary's adjustment is hereby modified to the amount claimed by the Provider.

Issue 7. FICA and Federal Withholding

The Board finds that the Provider did not provide documentation to support the allocation of FICA and federal withholding taxes or their liquidation. The Intermediary's adjustment disallowing FICA and federal withholding taxes is affirmed.

Issue 8. Health Insurance – Physical Therapy

The Board finds that the Provider did not provide documentation to support its claim. The Intermediary's adjustment disallowing health insurance costs is affirmed.

Issue 9. Consultant Expenses

The Board finds that the Provider did not provide documentation to support its claim. The Intermediary's adjustment disallowing consultant expenses is affirmed.

Issue 10. Contracted Therapy – Occupational Therapy

The Board finds that the Provider did not present sufficient documentation to support the allocation of its costs for occupational therapy. The Board finds that the adjustments were incorrect with regard to the placement of limits on occupational therapy costs and the disallowance of other costs when reconciling the cost report to the general ledger. The Intermediary's adjustments are hereby modified to allow these costs excluded in error.

Issue 11. Contracted Therapy – Speech Therapy

The Board finds that the Provider did not present sufficient documentation to support its allocation of costs for contracted speech therapy. The Board finds that the adjustments were incorrect with regard to the placement of limits on speech therapy costs and the disallowance of other costs when reconciling the cost report to the general ledger. The Intermediary's adjustments are modified to allow the costs excluded in error.

Issue 12. Auto Expense

The Board finds that the Provider did not provide the documentation to support its claim. The Intermediary's adjustments disallowing auto expenses are affirmed.

Issue 13. Auto Lease Expense

This issue was withdrawn by the Provider.

Issue 14. Administrative Recruiting

The Board finds that the Provider did not provide sufficient documentation to fully support its claim. However, the Board also finds that the Intermediary's subsequent revision to its original adjustment to allow $3,000 in properly documented administrative recruiting costs to be proper.

Issue 15. Telephone Expense

The Board finds that the Provider did not provide sufficient documentation to fully support its initial claim. However, after reviewing additional invoice copies subsequently submitted by the Provider that could be traced to the general ledger, the Intermediary

revised its original adjustment to allow $9,325 in telephone expenses. The Board finds the Intermediary's revision to be proper.

Issue 16. Accounting Expense

The Board finds that the Provider presented sufficient documentation to support its accounting expenses. The Intermediary's adjustment disallowing accounting expense is reversed.

Issue 17. Occupational Therapy Dues

The Board finds that the Provider did not provide any documentation to support its claim. The Intermediary's adjustments disallowing occupational therapy dues are affirmed.

Issue 18. Administrative Dues

The Board finds that the Provider did not submit sufficient documentation to support its request that all of its claimed costs for administrative dues be allowed, and the additional documentation subsequently submitted by the Provider was insufficient to support any additional reimbursement. The Intermediary's disallowance of Provider's undocumented administrative dues is affirmed.

Issue 19. Nursing Home Rent

The Board finds that the Provider did not provide satisfactory documentation to support its entire claim but that Provider subsequently supplied lease agreements which the Intermediary agreed were sufficient to allow an additional $5,500 in a revised adjustment. The Intermediary's proposed revised adjustment to allow and additional $5,500 in reimbursement was proper.

Issue 20. Rent Expense

The Board finds that the Provider did not provide the documentation to support its claim. The Intermediary's adjustments disallowing rent expense are affirmed.

Issue 21. Office Lease Expense

The Board finds that the Provider did not provide satisfactory documentation to support its entire claim but that Provider subsequently supplied lease agreements which the Intermediary agreed were sufficient to allow an additional $7,071 in a revised adjustment. The Intermediary's proposed revised adjustment to allow and additional $7,071 in reimbursement was proper.

Issue 22. Charges – Occupational, Physical and Speech Therapy

The Board finds that the Provider did not provide any documentation to support its claim. The Intermediary adjustments are affirmed.

Issue 23. Additional Costs for Depreciation, Contract Services- Occupational Therapy, Recruiting- Physical Therapy Recruiting- Administrative and Accounting

The Board remands the depreciation issue to the Intermediary to review the previously approved depreciation schedule and allow the appropriate depreciation expense. With respect to the other costs, the Board notes that the Provider did not claim them and the Intermediary did not make any audit adjustments. Therefore, the Board finds that they are not subject to review.

BOARD MEMBERS PARTICIPATING:

Suzanne Cochran, Esquire
Gary Blodgett, D.D.S.
Elaine Crews Powell, CPA
Anjali Mulchandani-West

FOR THE BOARD:

DATE: August 4, 2006

Suzanne Cochran, Esquire
Chairman