PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

ON THE RECORD
2007-D77

PROVIDER -
Logos Healthcare Rehabilitation of Tennessee, Inc.
Franklin, TN

Provider No.: 44-6530

vs.

INTERMEDIARY -
BlueCross BlueShield Association/ Palmetto Government Benefits Adminstrators

DATE OF HEARING -
June 10, 2005

Cost Reporting Period Ended -
December 31, 1994

CASE NO.: 00-3356

INDEX

ISSUES: [1]

1. Did the Intermediary improperly reopen the cost report?
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5. Was the Intermediary's adjustment to travel – speech therapy proper?
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9. Was the Intermediary's adjustment to accounting expense proper?
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15. Was the Intermediary's adjustment to interim payments proper? (Provider Issue 16)
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17. Was the Provider's request for costs incurred in the settling of cost reports after termination from the Medicare program proper? (Provider Issue 15)

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 under Medicare law and under interpretive guidelines published by CMS. See, 42 U.S.C. §1395h, 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 portion of those costs to be allocated to Medicare. 42 C.F.R. §413.20. The fiscal intermediary reviews the cost report, determines the total amount of Medicare reimbursement due the provider and issues the provider a Notice of Program Reimbursement (NPR). 42 C.F.R. §405.1803. A provider dissatisfied with the intermediary's final determination of total

[1] The Provider and Intermediary issue numbers are the same in this case except for issues 15 through 17. For simplicity, this decision uses the Intermediary's issue numbers and notes the different Provider issue numbers in parenthesis.

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 of Tennessee, Incorporated (the Provider) is a privately owned, for-profit, outpatient rehabilitation facility located in Franklin, Tennessee. The Provider was one of three Medicare-certified facilities in the PTK Management, Incorporated (PTK) chain of healthcare facilities. The Provider furnished outpatient physical, speech, and occupational therapy to Medicare patients in various nursing homes. The Provider claimed costs for its facility's services on its fiscal year ended December 31, 1994 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, Incorporated (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 Provider Reimbursement Review Board (Board) and met the jurisdictional requirements of 42 C.F.R. §§405.1831-405.1841.

The Board held a hearing for this case on November 7, 2001. Because of concerns raised at the hearing, the Board suspended the hearing and agreed to hear this case on the written record. See, 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 asked that additional audit work be performed and 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 made post-audit adjustments. See Exhibit I-4.

In order to facilitate consideration of the case on the record, the Board asked the Intermediary to submit a supplemental position paper that addressed any costs disallowed after the reaudit and state: (1) why the initial audit adjustment was made; (2) what additional documentation the Provider submitted; and (3) why that documentation was not sufficient to reverse the adjustment.[3] After receipt of the Intermediary's supplemental position paper, the Provider was permitted to submit a brief in response to the Intermediary's revised position 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.

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[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.

[3] See, Board letter dated January 28, 2005.

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

Issue 1. Did the Intermediary improperly reopen the cost report?

FACTS:

The Provider filed its Medicare cost report for FYE December 31, 1994 on March 31, 1995. The Intermediary issued its NPR for fiscal year 1994 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, 1994 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:

After consideration of the Medicare law and guidelines, the parties' contentions, and evidence presented, the Board 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 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 were 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, 1994 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 2. Was the Intermediary's adjustment to contract services - administrative proper?

FACTS:

The Provider claimed contract services – administrative which the Intermediary disallow due to lack of documentation. After reviewing additional documentation submitted by the Provider, the Intermediary allowed additional costs where adequate documentation could be traced to the general ledger. See, Intermediary's Supplemental Position Paper at 13.

PARTIES' CONTENTIONS:

The Provider asserts that the Intermediary failed to conduct a review of the documentation that was available at the facility and, therefore, has no basis to disallow these costs.

After reviewing the Provider's submission of additional documentation which consisted of invoices and corresponding checks, the Intermediary allowed some additional cost for contract services – administrative where there was adequate documentation that could be traced to the general ledger. See, Intermediary's Supplemental Position Paper, Exhibit I-6 at 19-24.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

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

Based on the documentation relied on by the Intermediary to support its decision to revise its adjustment, the Board finds that the Intermediary's proposed revision to it's adjustment is proper.

Issues 3-4. Were the Intermediary's adjustments to contract services – speech and occupational therapy proper?

FACTS:

The Provider claimed costs for contract services – speech and occupational therapy which the Intermediary disallow due to lack of documentation. After reviewing additional documentation supplied by the Provider, the Intermediary did not allow any additional contract services due to inadequate documentation. In addition, the Intermediary proposed additional adjustments for errors in its original determination where invoices were allowed that should not have been. See, Intermediary's Supplemental Position Paper at 14-16.

PARTIES' CONTENTIONS:

The Provider asserts that the Intermediary failed to conduct a review of the documentation that was available at the facility and, therefore, has no basis to disallow these costs. The Provider also notes that the Intermediary retroactively applied a salary equivalency amount (SEA) to this cost and that CMS had not published any SEA to be used on 1994 cost reports.

The Providers submitted additional documentation in the form of invoices and copies of corresponding checks showing that the Provider paid the invoice, but the Intermediary found this documentation to be inadequate and did not allow any additional costs. The Intermediary also proposed to correct errors in its original determination where invoices were allowed that should not have been. See, Intermediary's Supplemental Position Paper pages 14-15 and Exhibit I-6 at pages 19-24.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

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

The Board notes that the Provider did not present adequate documentation to support its claim. Absent such documentation, the Board finds that the Intermediary's proposed revision to its adjustment is proper. The Board agrees with the Provider that no SEA should apply in this 1994 cost report, however, since the Provider did not support its claim, any increase in the amount allowed from reversing the SEA would be immaterial.

Issue. 5. Was the Intermediary's adjustment to travel – speech therapy proper?

FACTS:

The Provider claimed costs for travel – speech therapy which the Intermediary disallow due to lack of documentation. After reviewing additional documentation supplied by the Provider, the Intermediary allowed additional costs where there was adequate documentation that could be traced to the general ledger. See, Intermediary's Supplemental Position Paper at 15-16.

PARTIES' CONTENTIONS:

The Provider asserts that the Intermediary failed to conduct a review of the documentation that was available at the facility and, therefore, has no basis to disallow these costs.

After reviewing the Provider's submission of additional documentation which consisted of invoices and copies of corresponding checks showing that the Provider paid the invoice, the Intermediary allowed additional travel – speech therapy where the costs were

supported by adequate documentation and could be traced to the general ledger. See, Intermediary's Supplemental Position Paper Exhibit I-6 at pages 10-11.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

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

The Board notes that the Provider presented additional documentation to support its claim. Absent any documentation in the record, the Board finds that the Intermediary's proposed revision to its adjustment is proper

Issues 6-8. Were the Intermediary's adjustments to travel – physical therapy, occupational therapy and administrative proper?

FACTS:

The Provider claimed costs for travel – physical therapy, occupational therapy, speech therapy and administrative which the Intermediary disallowed due to lack of documentation. After reviewing the additional documentation supplied by the Provider, the Intermediary did not allow any additional expenses because the documentation was inadequate. See, Intermediary's Supplemental Position Paper at 15-18.

PARTIES' CONTENTIONS:

The Provider asserts that the Intermediary failed to conduct a review of the documentation that was available at the facility and, therefore, has no basis to disallow these costs.

After reviewing the Provider's submission of additional documentation in the form of expense reports and invoices the Intermediary did not allow any additional costs because the documentation was inadequate. See, Intermediary's Supplemental Position Paper, Exhibit I-6 at pages 10-13.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

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

The Provider did not present adequate documentation to support its claim. Absent such documentation, the Board finds that the Intermediary's initial adjustment was proper.

Issue 9. Was the Intermediary's adjustment to accounting fees proper?

FACTS:

The Provider claimed costs for accounting fees which the Intermediary disallowed due to lack of supporting documentation. After reviewing additional documentation submitted by the Provider, the Intermediary allowed additional documented costs. See, Intermediary's Supplemental Position Paper at 18.

PARTIES' CONTENTIONS:

The Provider states that the Intermediary denied accounting fees for those months for which invoices were not provided. The Provider contends that the Intermediary's requirement to obtain and review 100 percent of the invoices is unreasonable.

After reviewing the Provider's submission of additional documentation in the form of invoices and other miscellaneous documents, the Intermediary allowed additional accounting fees for which there was adequate supporting documentation. See, Intermediary's Supplemental Position Paper, Exhibit I-6 at 17-18.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

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

The Provider presented documentation to support its claim and that the Intermediary's allowance of additional accounting fees is proper.

Issue 10. Was the Intermediary's adjustment to telephone expense proper?

FACTS:

The Provider claimed telephone expense which the Intermediary disallowed due to lack of supporting documentation. After reviewing additional documentation submitted by the Provider, the Intermediary allowed additional telephone expense for which there was adequate documentation. See, Intermediary's Supplemental Position Paper at 18-19.

PARTIES' CONTENTIONS:

The Provider asserts that the Intermediary failed to conduct a review of the documentation that was available at the facility and, therefore, has no basis to disallow these costs.

After reviewing the Provider's submission of additional documentation in the form of invoices, corresponding checks paid by the Provider and other miscellaneous documents, the Intermediary allowed additional telephone expense where there was supporting documentation. See, Intermediary's Supplemental Position Paper, Exhibit I-6 at 31-34.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

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

The Board notes that the Provider presented additional documentation to support its claim and finds that the Intermediary's proposed revision to its adjustment is proper.

Issue 11. Was the Intermediary's adjustment to office supplies proper?

FACTS:

The Provider claimed office supply costs which the Intermediary adjusted due to lack of supporting documentation. After reviewing additional documentation submitted by the Provider, the Intermediary allowed additional costs for which there was adequate documentation. See, Intermediary's Supplemental Position Paper at 19.

PARTIES' CONTENTIONS:

The Provider asserts that the Intermediary failed to conduct a review of the documentation that was available at the facility and, therefore, has no basis to disallow these costs.

After reviewing the Provider's submission of additional documentation in the form of invoices, corresponding checks paid by the Provider and other miscellaneous documents, the Intermediary allowed additional office supply costs where there was supporting documentation. See, Intermediary's Supplemental Position Paper, Exhibit I-6 at 14-16.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

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

The Board notes that the Provider presented additional documentation to support its claim and finds the Intermediary's allowance of additional office supply costs proper.

Issue 12. Was the Intermediary's adjustment to recruiting costs – other proper?

FACTS:

The Provider claimed recruiting costs – other then which the Intermediary disallowed due to lack of supporting documentation. After reviewing additional documentation submitted by the Provider, the Intermediary allowed additional costs for which there was adequate documentation. See, Intermediary's Supplemental Position Paper at 19-20.

PARTIES' CONTENTIONS:

The Provider asserts that the Intermediary workpapers indicate that it was provided with checks for $8,111 to support this cost; however, it appears that the Intermediary failed to properly review the documentation and, therefore, has no basis to disallow these costs.

After reviewing the Provider's submission of additional documentation in the form of invoices, corresponding checks paid by the Provider and other miscellaneous documents, the Intermediary allowed recruiting costs - other where there was supporting documentation. See, Intermediary's Supplemental Position Paper, Exhibit I-6 at 7-9.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

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

The Board notes that the Provider submitted additional documentation to support its recruiting costs and finds the Intermediary's allowance of additional cost is proper.

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

FACTS:

The Provider claimed rent expense which the Intermediary disallowed due to lack of supporting documentation. After reviewing additional documentation submitted by the Provider, the Intermediary allowed additional rent expense for which there was adequate documentation. See, Intermediary's Supplemental Position Paper at 20.

PARTIES' CONTENTIONS:

The Provider asserts that the amount denied was for temporary housing for a transferred employee. The Provider claims that it provided checks for the rent expense, but the Intermediary failed to review the invoices.

After reviewing the Provider's submission of additional documentation in the form of invoices, lease copies, corresponding checks paid by the Provider and other miscellaneous documents, the Intermediary allowed additional rent expense where adequate documentation was submitted. See, Intermediary's Supplemental Position Paper, Exhibit I-6 at 28-29.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

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

The Board notes that the Provider submitted additional documentation to support its rent expense, and finds that the Intermediary's allowance of those costs is proper.

Issue 14. Was the Intermediary's adjustment to total expenses proper?

FACTS:

The Intermediary made adjustments to reconcile total expenses listed by the Provider on trial balance of expenses in the as-filed cost report (worksheet A) to the Provider's financial statements. After reviewing the Provider's revised trial balance, the Intermediary proposed to reverse its original adjustment to agree with the Provider's documentation. See, Intermediary's Supplemental Position Paper at 20-21.

PARTIES' CONTENTIONS:

The Provider asserts that there was no request for a reconciliation of expenses, no workpaper to support the adjustment and this may represent a duplication of other disallowed costs. The Provider contends that the adjustments were made without any basis and should be reversed.

After reviewing the Provider's submission of a revised working trial balance, the Intermediary proposed a reversal of its original adjustment to agree with the Provider's documentation. See, Intermediary's Supplemental Position Paper, Exhibit I-6 at 1-4.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

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

The Board notes that the Intermediary has proposed reversing its original adjustment to agree with the documentation submitted by the Provider. The Board finds that the Intermediary's proposed adjustment to agree with the Provider's documentation is proper.

Issue 15. Was the Intermediary's adjustment to interim payments proper?

FACTS:

The Intermediary changed the amount of interim payments reported on the as-filed cost report.

PARTIES' CONTENTIONS:

The Provider claims that the Intermediary changed the amount of interim payments reported on the as-filed cost report without including an adjustment on the audit

adjustment report. The Provider requests that the interim payments reported on the as-filed cost report be reinstated.

The Intermediary states that when the cost report is revised it will review the total interim payment to ensure that it reflects the amount on the Provider Statistical and Reimbursement Summary. See, Intermediary's Supplemental Position Paper at 21.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

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

The Provider did not submit any documentation to support its claim regarding interim payments. The Board notes that the Intermediary proposes to review the total amount of interim payments to ensure that it reflects the amount on the Provider Statistical and Reimbursement Summary. The Board finds the Intermediary's proposal appropriate and remands this issue to the Intermediary to make the necessary adjustments.

Issue 16. Was the Intermediary's adjustment to home office costs proper? (Provider Issue 17)

FACTS:

The Provider claimed home office costs and the Intermediary adjusted the Provider's cost report to agree with the audited home office cost statement. After its review of additional documentation supplied by the Provider, the Intermediary allowed some additional costs.

PARTIES' CONTENTIONS:

The Provider claims that it had centralized administrative services at its home office, PTK management, Inc. The Provider states that the costs of these services were allocated to the individual entities using HCFA Form 2088. The Provider asserts that these costs had been allowed in 1992 and subsequent years but that the Intermediary unreasonably requested documentation for 88.71 percent of the costs claimed. In addition, the Provider also presented specific arguments for each of the audited categories.

After reviewing the Provider's submission of additional information to support a change in home office costs, the Intermediary allowed some additional costs.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

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

Neither the Provider's nor the Intermediary's position paper adequately addresses this issue or presents sufficient documentation and/or explanation to allow the Board to decide the issue. The Board is aware that the home office is not a provider and that costs

incurred by the home office are allocated to the entities served by the home office. The problem with these costs, in addition to the lack of adequate documentation, is the lack of support for the allocation of home office costs to the Provider. The Provider claims that its cost allocation was allowed in fiscal 1992. The Board finds, however, that whatever the circumstances were in fiscal year 1992, the Provider is not relieved of its obligation to support its allocation in the current fiscal year. Without further explanation and documentation from the Provider, the Board finds the Intermediary's proposed adjustment to its initial disallowance is proper.

Issue 17. Was the Provider's request for costs incurred in settling the cost report after termination from the Medicare program proper? (Provider Issue 15)

FACTS:

The Provider requested that additional costs incurred by the home office in settling the 1993 through 1997 cost reports with the Intermediary after termination from the Medicare program be included in the cost report under appeal. The Intermediary adjusted the Provider's cost report to agree with the audited home office cost statement. After its review of additional documentation supplied by the Provider, the Intermediary did not allow any additional costs because these costs should be claimed in the Provider's terminating cost report. See, Intermediary's Supplemental Position Paper at 22.

PARTIES' CONTENTIONS:

The Provider notes that CMS Pub. 15-1 §2176 states that direct administrative costs, including legal and hearing fees, incurred in terminating from the Medicare program are allowable.

The Intermediary states that these costs are not related to an audit adjustment in 1997. The Intermediary notes that the Provider terminated from the program on April 30, 1999, and that any allowable termination costs should be included in its terminating cost report in 1999. The Intermediary states that it cannot allow these costs in a cost report for a period five years sooner because the regulation at 42 C.F.R. §413.9 only allows actual costs incurred during that time period, not future costs.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

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

The Board notes that termination costs are allowable in a terminating cost report. However, since the Provider terminated from the Medicare program in 1999, it should claim those costs in its 1999 terminating cost report. The Board finds no basis to add these costs to the fiscal year at issue.

DECISIONS AND ORDERS:

Issue 1. Did the Intermediary improperly reopen the cost report?

The Board finds that the Provider's December 31, 1994 as-filed cost report did not become an Intermediary final determination and that the Intermediary's June 27, 2000 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 2. Was the Intermediary's adjustment to contract services – administrative proper?

The Board finds that the Provider submitted additional documentation to the Intermediary to support a revision to the Intermediary's original adjustment and affirms the Intermediary's proposed revision to allow additional contract services – administrative costs.

Issues 3-4. Were the Intermediary's adjustments to contract services – speech and occupational therapy proper?

The Board finds that the Provider did not present adequate documentation to support its claim. The Board also finds that the Intermediary's proposed disallowance for errors found in its original determination is proper. The Intermediary's proposed revisions to its adjustment are proper.

Issue 5. Was the Intermediary's adjustment to travel – speech therapy proper?

The Board finds that the Provider submitted additional documentation to the Intermediary to support a revision to the Intermediary's original adjustment and affirms the Intermediary's proposed revision to allow additional travel – speech therapy costs.

Issues 6-8. Were the Intermediary's adjustments to travel – physical therapy, occupational therapy and administrative proper?

The Board finds that the Provider did not present sufficient documentation to support its claim. The Intermediary's initial adjustment was proper.

Issue 9. Was the Intermediary's adjustment to accounting expense proper?

The Board finds that the Provider submitted additional documentation to the Intermediary to support a revision to the Intermediary's original adjustment and affirms the Intermediary's proposed revision to allow additional accounting expense costs.

Issue 10. Was the Intermediary's adjustment to telephone expense proper?

The Board finds that the Provider submitted additional documentation to the Intermediary to support a revision to the Intermediary's original adjustment and affirms the Intermediary's proposed revision to allow additional telephone expense costs.

Issue 11. Was the Intermediary's adjustment to office supplies proper?

The Board finds that the Provider submitted additional documentation to the Intermediary to support a revision to the Intermediary's original adjustment and affirms the Intermediary's proposed revision to allow additional office supplies costs.

Issue 12. Was the Intermediary's adjustment to recruiting costs proper?

The Board finds that the Provider submitted additional documentation to the Intermediary to support a revision to the Intermediary's original adjustment and affirms the Intermediary's proposed revision to allow additional recruiting costs.

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

The Board finds that the Provider submitted additional documentation to the Intermediary to support a revision to the Intermediary's original adjustment and affirms the Intermediary's proposed revision to allow additional rent expense costs.

Issue 14. Was the Intermediary's adjustment to total expenses proper?

The Board finds that the Intermediary proposed reversal of its original adjustment to agree with the Provider's documentation is proper.

Issue 15. Was the Intermediary's adjustment to interim payments proper? (Provider Issue 16)

The Board finds that the Provider did not present documentation to support its claim regarding interim payments. The Board remands this matter to the Intermediary to review the total amount of interim payment on the revised cost report to ensure that it reflects the amount on the Provider Statistical and Reimbursement Summary.

Issue 16. Was the Intermediary's adjustment to home office costs proper? (Provider Issue 17)

The Board finds that the Intermediary properly allowed additional home office administrative costs following the Provider's submission of supporting documentation and affirms the Intermediary's adjustments.

Issue 17. Was the Provider's request for costs incurred in settling the cost reports after termination from the Medicare program proper? (Provider Issue 15)

The Board finds that these termination costs should be claimed in the Provider's 1999 terminating cost report. The Board finds no basis to add these costs to the fiscal year at issue.

BOARD MEMBERS PARTICIPATING:

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

FOR THE BOARD:

Suzanne Cochran, Esquire
Chairperson

DATE: September 27, 2007