PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

ON THE RECORD
2007-D69

PROVIDER -
Logos Healthcare Rehabilitation, Inc.
Boone, NC

Provider No.: 34-6538

vs.

INTERMEDIARY -
BlueCross BlueShield Association/
Palmetto Government Benefits
Administrators

DATE OF HEARING -
June 10, 2005

Cost Reporting Period Ended -
December 31, 1994

CASE NO.: 00-3348

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[1] The Provider's Position Paper lists 30 issues with issue Nos. 22 and 29 marked "deleted." The Intermediary's position paper lists 28 issues. For simplicity, the Intermediary issue numbers have been used and the corresponding Provider issue numbers are noted after the issue statement.

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. 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 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, 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, 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 met the jurisdictional requirements of 42 C.F.R. §405.1831-405.1841. The amount of Medicare reimbursement for all issues is approximately $5,607,056.[3]

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

[3] Intermediary's Supplemental Position Paper at 1.

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 asked 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.[4]

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. 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. The amount of Medicare reimbursement at issue is approximately $2,740,771.

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

[4] Intermediary's Supplemental Position Paper Exhibit I-4.

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 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 had 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; 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 physical therapy salaries proper?

FACTS:

The Intermediary disallowed the Provider's claimed physical therapy salary costs for lack of documentation. The Board asked the Provider to 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 $1,038,095.

PARTIES' CONTENTIONS:

The Provider asserts that in order to audit salaries, the Intermediary is required to test the Provider's payroll system, use the employees' 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 forms did not reconcile to salaries claimed on the as-filed cost report. The Provider asserts that the 1099 and 941 forms 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 forms 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 was 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 cost 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 which entity in the chain of providers received the services. 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 Board notes that the documentation in the record, Exhibit I-14 at 1-26, contains quarterly tax and wage reports, 1099 forms related to rent and a number of checks. There is no explanation of the documentation or its meaning. The Board believes that even if the W-2s and 941s had been furnished, they would have been insufficient, by themselves, to support the allocation of physical therapy salary among the chain's components. 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 3. 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 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 $48,955.

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 agencies. The Provider claims that journal entries demonstrating the allocation were furnished to the Intermediary. Exhibit P-3(b). The Provider argues that the method of allocation was the same in 1992, and it had been reviewed and accepted by the Intermediary.

The Intermediary indicates that it initially removed the costs of contract services for occupational therapy due to lack of supporting documentation. The Intermediary states that the additional documentation submitted was incomplete, not for the proper time period or insufficient to determine to which facility the expense related. 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-3(b). However, there is no explanation of the chart, of why pages 1 through 5 and 6 through 10 of the Exhibit have the same caption but different numbers, or how these figures support the Provider's argument. The Board did not 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, the Intermediary's adjustment to remove these costs was proper.

Issue 4. Was the Intermediary's adjustment to contracted speech therapy proper?

FACTS:

The costs of contract services for speech therapy 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 additional documentation supplied by the Provider, the Intermediary continued to deny the costs because the Provider did not support the basis for the allocation, except for an additional $1,076 for which complete documentation was submitted. Intermediary's Supplemental Position Paper. Exhibit I-6 at 17-19. The amount of Medicare reimbursement at issue is approximately $24,465.

PARTIES' CONTENTIONS:

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 therapists in the various agencies. The Provider claims that journal entries demonstrating the allocation were furnished to the Intermediary. Exhibit P-4(b). The Provider argues that the method of allocation was the same in 1992, and it had been reviewed and accepted by the Intermediary.

The Intermediary states that much of the information the Provider submitted to document its costs was incomplete, not for the proper time period or insufficient to determine to which

facility the expense related. However, the Intermediary did allow an additional $1,076 for contracted speech therapy for items submitted by the Provider that had sufficient documentation. Exhibit I-4 and I-6 at 17-19.

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 the evidence in the record is insufficient to support contracted services for speech therapy. The Board notes that the Provider claims that its cost allocation was allowed in fiscal 1992. However, the Board finds that whatever the circumstances were in fiscal year 1992, it does 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 it claims shows the allocated cost based on a monthly computation. Exhibit P-4(b). However, there is no explanation of the chart, of why pages 1 through 5 and 6 through 10 of the Exhibit have the same caption but different numbers, or how these figures support the Provider's argument. The Board found no documentation of journal entries or any other documentation to support the accrual and allocation of these costs to this Provider. Therefore, the Board finds that the Intermediary's adjustment was proper.

Issue 5. Was the Intermediary's adjustment to contracted administrative services proper?

BACKGROUND:

The costs of contracted administrative 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 a review of additional documentation supplied by the Provider, the Intermediary continued to deny the costs because the Provider did not support the basis for the allocation except for an additional $35 for which complete and sufficient documentation was submitted. Intermediary's Supplemental Position Paper. Exhibit I-4 at 27-39 and I-6 at 20-21. The amount of Medicare reimbursement at issue is approximately $19,610.

PARTIES' CONTENTIONS:

The Provider argues that the method of allocation of these costs was the same in 1992, and it had been reviewed and accepted by the Intermediary.

The Intermediary states that much of the information the Provider submitted to document its costs was incomplete, not for the proper time period or insufficient to determine to which facility the expense was related. The Intermediary did allow an additional $35 for contracted administrative services for one invoice that was complete.

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 the evidence in the record is insufficient to support contracted services for administration. The Board notes that the Provider claims that this cost allocation was allowed in fiscal 1992. However, the Board finds that whatever the circumstances were in fiscal year 1992, it does not relieve the Provider of its obligation to support its allocation in the current fiscal year. The Provider submitted inadequate documentation and no explanation of its claimed costs, and the Board finds that the Intermediary's revised adjustment allowing only $35 in additional costs was proper.

Issues 6-9. Were the Intermediary's adjustments to recruiting costs – physical therapy, occupational therapy, speech therapy and "other"- proper?

BACKGROUND:

The Provider claimed recruiting costs that the Intermediary initially denied due to lack of documentation. The Board asked the Provider to submit additional documentation, and the Intermediary reviewed that documentation. After its review, the Intermediary continued to deny the costs that could not be tied to the general ledger. Intermediary's Supplemental Position Paper. Exhibit I-6 at 7. The amount of Medicare reimbursement at issue is approximately $1,188 for physical therapy, $775 for occupational therapy, $525 for speech therapy, and $23,383 for "other."

PARTIES' CONTENTIONS:

The Provider claims that it furnished invoices and contracts to the Intermediary to support the claimed recruiting costs. The Provider argues 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 states that it initially removed recruiting expenses due to lack of supporting documentation, and the Provider subsequently furnished documentation consisting of invoice copies and cancelled checks for its review. The Intermediary asserts 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, and invoices that did not trace to the general ledger were not allowed. The Intermediary contends that the Provider did not submit sufficient documentation to allow any additional costs in this category. Exhibit I-6 at 7 and 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:

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 was not supported and the Intermediary's adjustments were proper.

Issue 10. Was the Intermediary's adjustment to recruiting costs – Rehab Resources proper?

BACKGROUND:

The recruiting fees were accumulated on the home office cost report and allocated to the Provider. The Intermediary requested documentation to support these costs. The Intermediary denied these costs due to lack of supporting documentation and because the fees were paid to an undisclosed related party, Rehab Resources. Exhibit P-10(a) and Exhibit I-10. The Board asked the Provider to submit additional documentation and that the Intermediary review the additional documentation. After its review, the Intermediary continued to deny the costs because the Provider's additional documentation did not support its claim. Intermediary's Supplemental Position Paper. Exhibits I-4 and I-6 at 9-10. The Intermediary also determined that its initial adjustment of $127,323, based on the Provider's financial statements, was incorrect and that the amount claimed on the cost report was $286,250. The Intermediary proposes to amend its adjustment to the $286,250 amount claimed on the cost report.

PARTIES' CONTENTIONS:

The Provider claims that Rehab Resources was not a related party. While acknowledging that its former employees formed Rehab Resources and that it provided Rehab Resources with assistance, the Provider indicates that no stockholder, employee or relative of the Provider had any ownership in Rehab Resources; therefore, it was not a related party. The Provider contends that even if the Board finds that it was related to Rehab Resources, it is still entitled to claim the actual costs of the related organization. However, the Provider points out that the Intermediary eliminated all of the costs of the related party without further review. The Provider submitted a list of the actual costs it believes should be approved even if the Board finds the parties to be related. Exhibit P-104 at 12-16.

The Intermediary disallowed the recruitment costs due to lack of documentation and the fact that the costs were paid to an undisclosed related party. The Intermediary asserts that the Provider did not furnish any additional documentation to support its claim; therefore, the Intermediary did not allow any recruiting costs. The Intermediary also states that its original adjustment was incorrect, and that additional amounts claimed on the cost report should also be disallowed. The Intermediary proposed a revised adjustment to remove the additional costs. Exhibit I-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:

The Board notes that the Provider acknowledged that a key employee, as well as other employees of Rehab Resources, were previous employees of PTK, and that PTK provided Rehab Resources with assistance. See Provider Position Paper, P-10 at 1. Based on this acknowledgement, the Board finds that the parties were related and that adjustment of the costs was proper. The Board finds, however, that the Intermediary improperly disallowed all costs for Rehab Resources instead of reducing the amount claimed to the costs of the related party. The Board notes that the Provider submitted Rehab Resources' 1994 income statement and final balance of expenses at Exhibit P-104 at 12-16 and that the Intermediary did not review these costs for reasonableness, accuracy or their allocation to the Provider and other entities served by PTK. The Board remands this issue to the Intermediary to review and allow the actual costs of the related party for which there is adequate documentation to support their allocation to the Provider.

Issues 11-14. Were the Intermediary's adjustments to seminar costs – physical therapy, occupational therapy, speech therapy and administrative - proper?

BACKGROUND:

The Intermediary disallowed the costs for seminars due to lack of supporting documentation. The Intermediary reviewed additional documentation furnished by the Provider and continued to deny the costs for lack of documentation, except for $250 related to occupational therapy. Intermediary's Supplemental Position Paper Exhibit I-4. The amount of Medicare reimbursement at issue is approximately $1,184 for physical therapy, $940 for occupational therapy, $355 for speech therapy and $7,319 for administrative.

PARTIES' CONTENTIONS:

The Provider claims that it provided the Intermediary with the general ledger and a detailed explanation of how these costs were related to patient care. 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 Intermediary initially denied seminar costs due to lack of documentation. The Intermediary reviewed additional information supplied by the Provider but only accepted one invoice for $250 as adequately documented and proposed a revised adjustment to allow this amount. See Exhibit I-14 at 56 and I-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:

The Board notes that the Provider did not furnish detailed explanation and documentation of these costs with its submission to the Board. The Board reviewed the documentation presented in the Intermediary's supplemental position paper. Exhibit I-14 at 47 through 58. The Board notes that the Intermediary allowed an additional $250 for a seminar. Id. at 56. The Board

finds sufficient documentation to support the seminar costs on March 25, 1994 for $447.23 and April 22, 1994 for $29.84. Id. at 50-52 and 57. The Board finds that the total revised allowable costs for seminars should include these additional costs, and that the total allowable seminar costs should be $727.07.

Issue 15. Was the Intermediary's adjustment to administrative dues proper?

BACKGROUND:

The Provider claimed costs of administrative dues which the Intermediary initially disallowed due to lack of documentation. After its review of additional documentation supplied by the Provider, the Intermediary continued to deny all but $300 of the claimed costs for lack of documentation. Intermediary's Supplemental Position Paper Exhibit I-4. The amount of Medicare reimbursement at issue is approximately $3,490.

PARTIES' CONTENTIONS:

The Provider claims that it provided the Intermediary with the general ledger and a detailed explanation of how these costs were related to patient care. 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 Intermediary initially denied administrative dues for lack of documentation. The Intermediary subsequently reviewed additional information supplied by the Provider but only accepted one invoice and a corresponding check for $300 as adequately documented and proposed a revised adjustment to allow this amount. See Exhibit I-14 at 59-75 and I-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:

The Board notes that the Provider did not present any detailed explanation and documentation with its submission to the Board. The Board reviewed the documentation presented in the Intermediary's supplementary position paper. Exhibit I-14 at 59 through 75. The Board notes that the Intermediary allowed an additional $300 for administrative dues to the National Association for the Support of Long Term Care. Exhibit I-6 at 31. The Board finds sufficient documentation to support additional payment to the same organization during this time period in the form of checks, in the amounts of $300, $300, $200, $350, $10, $350, and $100 in Exhibit I-14 pages 61, 62, 63, 64, 65, 66 and 68, respectively. The Board also finds that the receipt for payment of $180 in dues to the American Speech-Language-Hearing Association, documented at Exhibit I-14 at 69-70, should be allowed. The Board finds that other documentation at Exhibit I-14 at 71-74 is not acceptable because there are no checks to support payment of these costs. The Board does not find acceptable the $1,750 payment to the National Association for the Support of Long Term Care because documentation indicates that the payment was made for salary equivalency research. Exhibit I-14 at 75. The Board finds

that the revised allowable costs for administrative dues should be increased by the additional $1,518 noted above, for a total of $1,818.

Issues 16 -19. Were the Intermediary's adjustments to supplies for physical therapy, occupational therapy, speech therapy and administration proper?

BACKGROUND:

The Provider claimed the costs of supplies for physical therapy, occupational therapy, speech therapy and administration which the Intermediary initially denied due to lack of documentation. After reviewing additional documentation supplied by the Provider, the Intermediary continued to deny the costs because invoices furnished did not reconcile to the general ledger. Intermediary's Supplemental Position Paper. Exhibit I-6 at 33-46. The amount of Medicare reimbursement at issue is approximately $18,274 for physical therapy, $20,282 for occupational therapy, $2,775 for speech therapy and $12,608 for administration.

PARTIES' CONTENTIONS:

The Provider claims that it provided the Intermediary with the general ledger and a detailed explanation of how these costs were related to patient care. 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 Intermediary initially denied supply costs due to lack of documentation, and the Intermediary maintains that Provider's additional documentation was not sufficient to allow any 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:

Based on the record provided by the Intermediary and Provider, the Board did not find sufficient documentation to support the Provider's claim for supplies. The Board finds that the Intermediary's adjustments due to lack of documentation were proper.

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

BACKGROUND:

The Provider claimed accounting expenses which the Intermediary initially denied due to lack of documentation. After its review of 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 $14,852.

PARTIES' CONTENTIONS:

The Provider claims that the Intermediary disallowed its accounting costs because it did not provide copies of all of the invoices. The Provider indicated that it furnished invoices totaling $11,925 and amounting to 44.53 percent of the total transactions. The Provider claims that it should not have to produce 100 percent of its invoices.

The Intermediary indicates that it initially disallowed accounting expenses due to lack of supporting documentation but that the Provider supplied documentation for review consisting of invoice copies. The Intermediary states that some of the documents were incomplete or illegible, some were duplicates of PTK Management accounts, and some had previously been allowed. Based on its additional audit work, the Intermediary did not allow any additional costs. Exhibit I-6 at 5-6.

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 the Intermediary's insistence on 100 percent of invoices was not reasonable. The Provider submitted 44.53 percent of its invoices to support its accounting expense, and the Intermediary made no disallowance for costs unrelated to patient care. The Board finds that the Intermediary should have allowed all accounting costs based on the high percentage of valid accounting invoices it was provided. Therefore, the Intermediary's adjustment is reversed.

Issue 21. Was the Intermediary's adjustment to telephone expense proper?

BACKGROUND:

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 proposed to allow an additional $209 for two invoices that could be traced to the general ledger. The amount of Medicare reimbursement at issue is approximately $22,305.

PARTIES' CONTENTIONS:

The Provider claims that it provided the Intermediary with the general ledger and a detailed explanation of how these costs were related to patient care. 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 Intermediary initially denied telephone expenses due to lack of documentation. The Intermediary proposes allowing an additional $209 for two invoices that could be traced to the general ledger. Intermediary's Supplemental Position Paper. Exhibit I-6 at 57-64.

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 reviewed the workpapers of the Intermediary and notes that the Intermediary reviewed the Provider's invoices for telephone services. Exhibit I-6 at 57-64. These workpapers indicate that the Provider furnished extensive invoices by telephone number. While the Board cannot verify the necessity for all of the different types of telephone expenses for all of the various locations, the Board concludes that the Provider had continuous telephone expenses at its principal place of business in Boone, NC during the fiscal year and that these numbers can be identified. The Board finds that the expenses for the telephone numbers associated with the Provider's office in Boone, NC should be allowed and remands this issue to the Intermediary to identify and reimburse these costs.

Issue 22. Was the Intermediary's adjustment to auto lease expense proper?

BACKGROUND:

The Provider claimed auto lease costs which the Intermediary initially denied due to lack of documentation. The Intermediary did not allow any additional costs because the Provider did not submit any additional documentation. The amount of Medicare reimbursement at issue is approximately $4,097.

PARTIES' CONTENTIONS:

The Provider claims that the documentation was available at its facilities but the Intermediary did not audit it. Instead, the Provider asserts that the Intermediary required that the Provider copy all invoices and documentation and mail it to them. The Provider asserts that this was an unreasonable request.

The Intermediary initially denied these costs due to lack of documentation. The Intermediary did not allow any additional costs because the Provider did not submit any additional documentation. Intermediary's Supplemental Position Paper. Exhibit I-6 at 28.

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 does not find any evidence in the record to support the purpose for which these auto lease expenses were incurred. The Board finds the Intermediary's adjustment denying these costs for lack of documentation was proper.

Issue 23. Was the Intermediary's adjustment to nursing home lease expense proper?

BACKGROUND:

The Provider claimed nursing home lease expense on its cost report. 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 allow any additional costs because the documentation did not relate to the proper fiscal year. Intermediary's Supplemental Position Paper. Exhibit I-6 at 76-94. The amount of Medicare reimbursement at issue is approximately $16,228.

PARTIES' CONTENTIONS:

The Provider claims that it is routine for providers to pay rent to skilled nursing facilities for their equipment and space used to provide patient care. The Provider indicates that this matter was reviewed by the Intermediary in detail in 1992, and that the Intermediary has no basis to deny these costs.

The Intermediary indicates that it initially denied these costs due to lack of supporting documentation, and that the documentation supplied by the Provider was not for the fiscal year at issue in this case. The Intermediary proposed no adjustment to the original adjustment denying these costs. Exhibit I-6 at 49-50.

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 the Provider's position paper did not present documentation to support the costs claimed. The Board reviewed the information presented in the Intermediary workpapers, Exhibit I-6 at 49-50, and documentation included in Exhibit I-14 at 76-94. The Board notes that the general ledger, Id. at 77, contains the names of nursing homes and amounts paid, however, the documentation pertains to fiscal year 1993. The Board also notes that the agreements with facilities, dated in 1992, do not match those claimed on the general ledger. The Board finds that the Provider did not submit sufficient documentation to support its claim for nursing home lease expenses; therefore, the Intermediary's adjustments were proper.

Issue 24. Was the Intermediary's adjustment to related party rental expense proper?

BACKGROUND:

The Provider claimed rental expense paid to Blust Properties which the Intermediary initially denied due to lack of documentation. The Provider submitted an amended cost report indicating that Blust Properties was a related party and requesting that the amount claimed be reduced to the actual costs of the related party. The Intermediary rejected the Provider's amended cost report and continued to disallow all costs for this related party. The Intermediary did not allow any additional costs because the Provider did not submit any

additional relevant documentation. The amount of Medicare reimbursement at issue is approximately $72,909.

PARTIES' CONTENTIONS:

The Provider asserts that Blust Properties, Inc. was a related party. Provider Supplemental Brief at 18. However, the Provider argues that this fact does not support the Intermediary's denial of all of these costs, and that it is entitled to claim the actual costs of its related party on its cost report.

The Intermediary indicates that it initially disallowed rental expenses due to lack of supporting documentation and later disallowed costs due to the undisclosed relatedness of the parties. The Intermediary states that the only documentation it received concerning rental expense was the information noted in Issue 23 above, and that material is unrelated to this issue. The Intermediary states that it did not allow any additional costs and proposed no revision to its original adjustment. Exhibit I-6 at 49-50.

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 Provider acknowledged that Blust Properties, Inc. was a related party, and the Board agrees with the Provider that the appropriate adjustment is to reduce the costs claimed to the actual costs of its related party. The Board notes, however, that the Provider did not present any documentation to support the costs it claimed of its related party. Without this information in the record, the Board finds that the Intermediary's adjustment disallowing the costs due to lack of documentation was proper.

Issue 25. Was the Intermediary's adjustment to office equipment lease expense proper?

BACKGROUND:

The Provider claimed office equipment lease expenses which the Intermediary initially denied due to lack of documentation. After its review of additional documentation supplied by the Provider, the Intermediary determined that complete documentation existed for only three invoices and proposed a revised adjustment to allow those expenses. The amount of Medicare reimbursement at issue is approximately $48,095.

PARTIES' CONTENTIONS:

The Provider claims that it provided the Intermediary with the general ledger and a detailed explanation of how these costs were related to patient care. 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 Intermediary indicates that it initially disallowed office equipment lease expenses due to lack of supporting documentation. The Intermediary notes that the Provider subsequently supplied some documentation, but that complete documentation existed for only three invoices totaling $2,789 in expenses. Exhibit I-6 at 51-56.

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 the Provider did not present any documentation in its position paper to support its claim for office equipment lease expense. The Board reviewed the documentation subsequently presented and workpapers in the Intermediary's Supplemental Position Paper Exhibits I-14 at 95-120 and I-6 at 51-56. Based on the documentation in the record, the Board could not determine whether the leased equipment was located at the home office or at the Provider's location or any basis for allocating home office equipment lease costs to the Provider. The Board finds that the Provider did not support its claim for additional costs other than those accepted by the Intermediary in its proposed revision to the adjustment for $2,798. The Board finds that the Intermediary's adjustments disallowing undocumented costs was proper.

Issue 26. Was the Intermediary's adjustment to insurance expenses proper?

BACKGROUND:

The Provider claimed insurance expenses which the Intermediary initially denied due to lack of documentation. After its review of additional documentation submitted by the Provider, the Intermediary did not allow any additional costs. The amount of Medicare reimbursement at issue is approximately $21,855.

PARTIES' CONTENTIONS:

The Provider claims that it furnished all requested documentation to support its insurance costs but that the Intermediary did not review it during its visit. The Provider claims that the Intermediary erroneously denied the costs for lack of documentation and then required the Provider to submit the documentation to their office in Miami, FL. The Provider asserts that it lacked the finances to respond to this unreasonable request and that the costs should be reinstated.

The Intermediary indicates that it initially disallowed insurance costs due to lack of documentation. The Intermediary notes that the Provider supplied documentation that consisted of one statement from the American Speech-Language Hearing Association, however, it appeared to relate to the Logos Speech and Hearing Company, another company owned by PTK Management. Exhibit I-14 at 121-124. Based on its audit work, the Intermediary did not allow any additional costs. Exhibit I-6 at 47-48.

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 Provider did not present any documentation in its position paper to support its claim. The Board reviewed the documentation and workpapers of the Intermediary in its Supplemental Position Paper Exhibits I-47-48 and I-14 at 121-124. The Board notes that the number of professional employees covered by the policy (68) suggests that the policy covered the large number of employees that worked out of the home office. Exhibit I-14 at 123. The Board was unable to discern from the documentation present whether the insurance costs were claimed by the Provider or as home office costs and, if they were home office costs, whether they were properly allocated among the PTK Management entities. Without relevant documentation, the Board finds that the Intermediary's adjustment disallowing these costs for lack of documentation was proper.

Issue 27. Was the Intermediary's adjustment to home office costs proper?

BACKGROUND:

The Provider claimed home office costs, and the Intermediary adjusted the as-filed 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. The amount of Medicare reimbursement at issue is approximately $1,304,463.

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 then allocated to the individual entities using HCFA Form 2088. The Provider asserts that these costs had been allowed in 1992 and subsequently years but that the Intermediary unreasonably requested documentation for 88.71 percent of the costs claimed in 1994. The Provider, in its position paper, discussed each home office adjustment made by the Intermediary.

The Intermediary disallowed certain home office costs due to lack of documentation. The Intermediary indicated that the Provider did not submit any additional information to support a revision to the home office adjustments; therefore, the Intermediary did not allow any 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 Board notes that the Intermediary's position paper does not adequately address the issues raised by the Provider. See Intermediary Supplemental Position Paper at 31. The Board notes

that the Provider discussed the components of the home office adjustment and included the Intermediary workpapers and some documentation. Provider Position Paper in Exhibit P-30. The Board finds, however, that the Provider did not present sufficient documentation and/or explanation to allow the Board to decide the issue. The Board notes 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. This problem has been noted in a number of the issues noted above, including issues 1-10, 25 and 26. The Board notes that 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, it does not relieve the Provider of its obligation to support its allocation in the current fiscal year. The Board also notes that it is not possible to determine whether some of the costs included within this issue were also included in previous issues. For example, the Provider included claimed costs for Blust Properties under this issue and under issue 25. Without further explanation and documentation from the Provider, the Board finds the Intermediary's adjustment for lack of documentation was proper.

Issue 28. Was the Provider's request for additional costs for depreciation proper?

BACKGROUND:

The Intermediary audited the Provider's 1992 cost report in 1995 and developed a depreciation schedule for the Provider. Because the depreciation schedule was developed in 1995, the Provider's filed 1994 cost report did not include the correct depreciation expense. The amount of Medicare reimbursement at issue is approximately $9,935.

PARTIES' CONTENTIONS:

The Provider asserts that the depreciation schedule prepared by the Intermediary during the audit of the1992 cost report should be used to correct the depreciation claim on the as-filed filed 1994 cost report.

The Intermediary indicated that the depreciation schedule prepared and approved by the Intermediary in previous years would be reviewed and the appropriate depreciation allowed. Intermediary Supplemental Position Paper at 31.

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 indicated that it would review the previously approved depreciation schedule and allow the appropriate depreciation expense. The Board remands this issue to the Intermediary to allow the appropriate depreciation expense.

DECISIONS AND ORDERS:

Issue 1. Did the Intermediary improperly reopen the cost report? (Provider Issue 1)

The Board finds that the Provider's December 31, 1994 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 2. Was the Intermediary's adjustment to physical therapy salaries proper? (Provider Issue 2)

The Board finds that the documentation submitted by the Provider does not clearly indicate the specific services that were provided by the physical therapists and the basis for the allocation of these costs to the Provider. The Intermediary's adjustment is affirmed.

Issue 3. Was the Intermediary's adjustment to contracted occupational therapy services proper? (Provider Issue 3)

The Board found no copies of journal entries or any other documentation to support the accrual and allocation of these costs to the Provider. The Intermediary's adjustment is affirmed.

Issue 4. Was the Intermediary's adjustment to contracted speech therapy services proper? (Provider Issue 4)

The Board found no documentation of journal entries or any other documentation to support the accrual and allocation of these costs to the Provider. The Intermediary's adjustment is affirmed.

Issue 5. Was the Intermediary's adjustment to contracted administrative services proper? (Provider Issue 5)

The Board finds that the Provider did not supply sufficient documentation to support the claimed costs or their allocation to the Provider. The Intermediary's revised adjustment allowing an additional $35 is affirmed.

Issues 6-9. Were the Intermediary's adjustments to recruiting costs – physical therapy, occupational therapy, speech therapy and "other" proper? (Provider Issues 6-9)

The Board finds that the Provider failed to provide any documentation in the record to support its claim for these costs. The Intermediary's adjustments are affirmed.

Issue 10. Was the Intermediary's adjustment to recruiting costs - Rehab Resources proper? (Provider Issue 10)

The Board finds that PTK and Rehab Resources were related parties; however, the Intermediary improperly disallowed all of the Rehab Resources costs instead of reducing the costs claimed to the costs of the related party. The Board remands this issue to the Intermediary to review and allow the actual costs of the related party for which there is adequate documentation to support their allocation to the Provider.

Issues 11-14. Were the Intermediary's adjustments to seminar costs – physical therapy, occupational therapy, speech therapy and administrative - proper?

The Board finds sufficient documentation to support the seminar cost on March 25, 1994 for $447.23 and on April 22, 1994 for $29.84 and notes that the Intermediary allowed an additional $250 for a seminar. Id. at 50-52, 56 and 57. The Board finds that the total revised allowable costs for seminars should be $727.07.

Issue 15. Was the Intermediary's adjustment to administrative dues proper? (Provider Issue 15)

The Board finds sufficient documentation of administrative dues in the record to support $1,518 in addition to the $300 that the Intermediary recognized. The Intermediary's adjustment is revised to allow a total of $1,818.

Issues 16-19. Were the Intermediary's adjustments to supplies for physical therapy, occupational therapy, speech therapy and administrative proper?

The Board did not find sufficient documentation to support the Provider's claim for supplies. The Intermediary's adjustments are affirmed.

Issue 20. Was the Intermediary's adjustment to accounting expense? (Provider Issue 20)

The Board finds that the Provider submitted adequate documentation to support its accounting costs. The Intermediary adjustment is reversed.

Issue 21. Was the Intermediary's adjustment to telephone expense proper? (Provider Issue 21)

The Board finds sufficient documentation in the record to support costs for the telephone numbers associated with the Provider's offices in Boone, NC. The Board remands this issue to the Intermediary to identify and reimburse these costs.

Issue 22. Was the Intermediary's adjustment to auto lease expense proper? (Provider Issue 23)

The Board did not find any evidence in the record to support the Provider's auto lease expense. The Intermediary's adjustment is affirmed.

Issue 23. Was the Intermediary's adjustment to nursing home lease expense proper? (Provider Issue 24)

The Board finds that the documentation in the record is insufficient to support the claimed nursing home lease expense. The Intermediary's adjustment is affirmed.

Issue 24. Was the Intermediary's adjustment to related party rent expense proper? (Provider Issue 25)

The Board finds that the Provider has not presented sufficient documentation to support its claim. The Intermediary's adjustment is affirmed.

Issue 25. Was the Intermediary's adjustment to office equipment lease expense proper? (Provider Issue 26)

The Board finds that the Provider did not support its claim for additional costs other than those accepted by the Intermediary. The Intermediary's proposed revision to its adjustment to allow $2,789 is affirmed.

Issue 26. Was the Intermediary's adjustment to insurance expense proper? (Provider Issue 27)

The Board finds that the Provider did not present any documentation to support its claim. The Intermediary's adjustment is affirmed.

Issue 27. Was the Intermediary's adjustment to home office costs proper? (Provider Issue 30)

The Board finds that the Provider did not present sufficient documentation and/or explanation to support its claim. The Intermediary adjustment is affirmed.

Issue 28. Was the Provider's request for additional costs for depreciation proper? (Provider Issue 28)

The Board finds that the Intermediary has agreed to review the previously approved depreciation schedule and allow the appropriate depreciation expense. The Board remands this issue to the Intermediary to allow the appropriate depreciation expense.

Board Members Participating:

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

DATE: September 17, 2007

FOR THE BOARD:

Suzanne Cochran, Esquire
Chairman