PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

ON THE RECORD
2007-D72

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, 1997

CASE NO.: 00-3351

INDEX

ISSUES:[1]

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15. Were the Provider's requests for the inclusion of costs incurred in settling the cost report after termination from the Medicare program proper? (Provider's Issue 14)

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 14 and 15. For simplicity, this decision uses the Intermediary's issue number and notes the different Provider issue number 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 Incorporated (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 Incorporated (PTK) chain of health care 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, 1997 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 proceedings and agreed to the Provider's request that the Board make its decision on the written record. See Tr. at 11.[3] 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 the Intermediary to perform additional audit work 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 post-audit adjustments. See, Exhibit I-4.

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 re-audit and state: 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.

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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 Blue Cross Blue Shield Association.

Issue 1. Was the Intermediary's adjustment to bad debts proper?

FACTS:

The Intermediary disallowed the Provider's bad debts 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.

PARTIES' CONTENTIONS:

The Provider asserts that it provided a list of its bad debts on its original cost report and that the Intermediary failed to conduct a review of the documentation that was available at the facility. Therefore, the Intermediary has no basis to disallow these costs.

The Intermediary initially denied the Provider's Medicare bad debts due to lack of supporting documentation. The Provider subsequently submitted a modified bad debt list and additional medical information. The Intermediary did not allow any additional reimbursement because the Provider failed to submit supporting documentation such as Medicare remittance advices. See, Intermediary Supplemental Position Paper at 8.

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:

There is insufficient evidence in the record to support the Provider's bad debt claims. The Board finds that without proper documentation, the Intermediary's adjustment was proper.

Issue 2. Was the Intermediary's adjustment to salaries proper?

FACTS:

The salaries for administrative and general (A&G), physical therapy, speech therapy and occupational therapy were accumulated at the home office level 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 of salaries.

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-2/1099s, 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 salaries, citing a lack of essential documentation. The Intermediary claims that the Provider failed to provide requested W-2s, and that the salaries on the 1099s and 941s did not reconcile to salaries claimed on the as-filed cost report. The Provider asserts that the 1099s and 941s cannot be reconciled with the cost report because the cost report salaries are stated on the accrual basis of accounting whereas the 1099s and 941s 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 W-2 forms for individual employees and an earnings report, but was unable to trace salaries into the general ledger. See, Intermediary's Supplemental Position Paper at 8. The Intermediary did not allow any additional salary 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 these salaries were accumulated at the home office level, 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 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 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 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 contract labor proper?

FACTS:

The Provider's claim for contract labor was initially denied due to lack of documentation. After review of additional documentation supplied by the Provider, the Intermediary continued to deny the costs because the documentation was inadequate.

PARTIES' CONTENTIONS:

The Provider claims that its contract labor costs for therapy services were legitimately incurred and 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 reviewed additional documentation supplied by the Provider but stated that the Provider did not furnish a detailed general ledger to which invoices would be traced. See, Intermediary Supplemental Position Paper at 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 finds that the Provider failed to provide sufficient documentation to support its claim for these costs. The Board finds that the Intermediary's adjustment due to lack of documentation was proper.

Issue 4. Was the Intermediary's adjustment to travel and lodging expense proper?

FACTS:

The Provider claimed travel and lodging expenses 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.

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 Intermediary denied the costs despite receiving additional documentation in the form of invoices because no detailed general ledger was provided to which the invoices could be traced. See, Intermediary Supplemental Position Paper at 10.

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:

There was insufficient evidence in the record to support the Provider's claim for travel and lodging expenses. The Board finds that without proper documentation, the Provider's claim for travel and lodging expenses is not supported, and the Intermediary's adjustment was proper.

Issue 5. Was the Intermediary's adjustment to utilities expense proper?

FACTS:

The Provider claimed utilities 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 of inadequate documentation.

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 Intermediary found additional documentation in the form of invoices to be insufficient because no detailed general ledger was provided to which the invoices could be traced. See, Intermediary Supplemental Position Paper at 10.

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:

There is insufficient evidence in the record to support the Provider's claim for its utility expenses. The Board finds that without proper documentation, the Provider's claim for utility expenses is not supported, and the Intermediary's adjustment was proper.

Issue 6. Was the Intermediary's adjustment to office supply expense proper?

FACTS:

The Provider claimed office supply expenses which the Intermediary initially denied due to lack of documentation. After reviewing additional documentation furnished by the Provider, the Intermediary continued to deny the costs because of inadequate documentation.

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 Intermediary found additional documentation in the form of invoices insufficient because no detailed general ledger was provided to which the invoices could be traced. See, Intermediary Supplemental Position Paper at 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:

There is insufficient evidence in the record to support the Provider's claim for office supply expenses. The Board finds that without proper documentation, the Provider's claim for office supply expenses is not supported, and the Intermediary's adjustment was proper.

Issue 7. Was the Intermediary's adjustment to dues and subscriptions expense proper?

FACTS:

The Intermediary disallowed other dues and subscription expenses due to lack of supporting documentation. After reviewing additional documentation furnished by the Provider, the Intermediary continued to deny the costs because of inadequate documentation.

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 Intermediary found additional documentation in the form of invoices insufficient because no detailed general ledger was provided to which the invoices could be traced. See, Intermediary Supplemental Position Paper at 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:

There is insufficient evidence in the record to support the Provider's claim for dues and subscriptions expense. The Board finds that without proper documentation, the Provider's claim for dues and subscriptions expense is not supported, and the Intermediary's adjustment was proper.

Issue 8. Was the Intermediary's adjustment to professional fees proper?

FACTS:

The Intermediary disallowed professional fees due to lack of supporting documentation. After reviewing additional documentation furnished by the Provider, the Intermediary continued to deny the costs because of inadequate documentation.

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 Intermediary found additional documentation in the form of invoices insufficient because no detailed general ledger was provided to which the invoices could be traced. See, Intermediary Supplemental Position Paper at 12.

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 professional fees at issue appear to be home office costs, see, Exhibit P-8(b), and there is no information to support the allocation of these costs to the Provider. The Board finds that without proper documentation, the Provider's claim for professional fees is not supported, and the Intermediary's adjustment was proper.

Issue 9. Was the Intermediary's adjustment to other expenses proper?

FACTS:

The Provider claimed other expenses related to administrative, physical therapy, speech therapy and occupational therapy which the Intermediary initially denied due to lack of documentation. The Provider did not submit additional documentation in support of these costs.

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 Intermediary notes that the Provider did not submit additional documentation and never furnished a detailed general ledger to which invoices could be traced. The Intermediary did not propose any change to its original adjustment because the Provider never furnished a detailed ledger.

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:

There is insufficient evidence in the record to support the Provider's claim for other expenses related to administrative, physical therapy, speech therapy and occupational therapy. The Board finds that without proper documentation, the Provider's claim for these other expenses is not supported, and the Intermediary's adjustment was proper.

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

BACKGROUND:

The Provider claimed rent expense which the Intermediary initially denied due to lack of documentation. After reviewing additional documentation supplied by the Provider, the Intermediary continued to disallow these costs.

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 Intermediary found additional documentation in the form of invoices, to be insufficient because no detailed general ledger was provided to which invoices could be traced. See, Intermediary Supplemental Position Paper at 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:

There is insufficient evidence in the record to support the Provider's claim for rent expense. The Board finds that without proper documentation, the Provider's claim for rent expense is not supported, and the Intermediary's adjustment was proper.

Issue 11. Was the Intermediary's adjustment to additional accounts payable/capital related costs proper?

FACTS:

The Provider claimed additional accounts payable/capital related costs which the Intermediary initially denied due to lack of documentation. After its additional audit work, the Intermediary continued to disallow these costs.

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 Intermediary notes that the Provider did not submit any additional documentation and, therefore, it did not propose any change to its original adjustment.

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:

There is insufficient evidence in the record to support the Provider's claim for additional accounts payable/capital related costs. The Board finds that without proper documentation, the Provider's claim for additional accounts payable/capital related costs is not supported, and the Intermediary's adjustment was proper.

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

FACTS:

The Provider claimed interest expense which the Intermediary initially denied due to lack of documentation. After its additional audit work, the Intermediary continued to deny these costs. See, Intermediary's Supplemental Position Paper at 14.

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 Intermediary notes that the Provider submitted additional invoices but that it did not provide a detailed general ledger to which invoices could be traced.

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:

There is insufficient evidence in the record to support the Provider's claim for interest expense. The Board finds that without proper documentation, the Provider's claim for interest expense is not supported, and the Intermediary's adjustment was proper.

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

FACTS:

The Provider claimed advertising expense which the Intermediary initially denied due to lack of documentation. After its additional audit work, the Intermediary continued to deny these costs. See, Intermediary's Supplemental Position Paper at 15.

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 Intermediary notes that the Provider submitted additional documentation but that it never provided a detailed general ledger to which it could traced the invoices.

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:

There is insufficient evidence in the record to support the Provider's claim for advertising expense. The Board finds that without proper documentation, the Provider's claim for advertising expense is not supported, and the Intermediary's adjustment was proper.

Issue 14. Was the Intermediary's adjustment to home office costs proper?

FACTS:

The Provider claimed costs allocated from the home office. The Intermediary adjusted the home office costs to agree with the audited home office cost statement. After its additional audit work, the Intermediary did not allow any additional costs.

PARTIES' CONTENTIONS:

The Provider states that administrative service costs had been accumulated at the home office and the costs were then allocated to the individual entities using the home office cost statement, HCFA Form 2088. The Provider claims that these costs had been allowed

in 1992 and other years, but in the current year audit, the Intermediary unreasonably requested documentation for 82.67 percent of the costs claimed for the year at issue. The Provider also presented specific arguments for each of the audited categories of home office costs.

The Intermediary disallowed home office costs due to lack of documentation. The Intermediary stated that the Provider did not submit any additional information to support a change in home office costs and, therefore, the Intermediary did not allow any 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:

The Intermediary's position paper does not adequately address the issues raised by the Provider. See, Intermediary Supplemental Position Paper at 15. The Provider discussed the components of the home office adjustment and included the Intermediary's workpapers and some documentation. See, Provider Position Paper in Exhibit P-15. The Board finds, however, that the Provider did not present sufficient documentation and/or explanation to allow the Board to decide the issue. Notably, the Provider did not furnish any support for the allocation of the home office costs to the providers in the chain. While the Provider claims that its home office cost allocation was allowed in fiscal 1992, 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 also notes that it is not possible to determine whether some of the cost claimed under this issue were also claimed in other issues. For example, the Provider claimed costs for travel under this issue as well as under issue 4 above. Without further explanation and documentation from the Provider, the Board finds the Intermediary's adjustment for lack of documentation was proper.

Issue 15. Were the Provider's requests for the inclusion of costs incurred in settling the cost report after termination from the Medicare program proper?

FACTS:

The Provider requested that additional costs incurred by the home office to settle the 1993 through 1997 cost reports with the Intermediary after its termination from the Medicare program be included as allowable in the cost reporting year at issue. See, Provider's Supplemental Brief at P-14.

PARTIES' CONTENTIONS:

The Provider asserts 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 in the settlement of cost reports with the Intermediary.

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 have been included in its 1999 terminating cost report. The Intermediary states that it cannot allow these costs in a cost report for a period two years prior 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. Since the Provider terminated from the Medicare program in 1999, it should have claimed 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. Was the Intermediary's adjustment to bad debts proper?

The Board finds that the Provider did not supply sufficient documentation to support its claim for bad debts. The Intermediary's adjustment for lack of documentation is affirmed.

Issue 2. Was the Intermediary's adjustment to salaries proper?

The Board found insufficient documentation to support the accrual and allocation of these costs to the Provider. The Intermediary adjustments are affirmed.

Issue 3. Was the Intermediary's adjustment to contract labor proper?

The Board finds that the Provider failed to provide sufficient documentation to support its claim. The Intermediary's adjustment disallowing these costs due to lack of documentation is affirmed.

Issue 4. Was the Intermediary's adjustment to travel and lodging expense proper?

The Board finds that the Provider failed to provide sufficient documentation to support its claim. The Intermediary's adjustment disallowing these costs due to lack of documentation is affirmed.

Issue 5. Was the Intermediary's adjustment to utilities expense proper?

The Board finds that the Provider failed to provide sufficient documentation to support its claim. The Intermediary's adjustment disallowing these costs due to lack of documentation is affirmed.

Issue 6. Was the Intermediary's adjustment to office supply expense proper?

The Board finds that the Provider failed to provide sufficient documentation to support its claim. The Intermediary's adjustment disallowing these costs due to lack of documentation is affirmed.

Issue 7. Was the Intermediary's adjustment to dues and subscriptions expense proper?

The Board finds that the Provider failed to provide sufficient documentation to support its claim. The Intermediary's adjustment disallowing these costs due to lack of documentation is affirmed.

Issue 8. Was the Intermediary's adjustment to professional fees proper?

The Board finds that the Provider failed to provide sufficient documentation to support its claim. In addition, the fees at issue appear to be home office costs. The Intermediary's adjustment disallowing these costs due to lack of documentation is affirmed.

Issue 9. Was the Intermediary's adjustment to other expenses proper?

The Board finds that the Provider failed to provide sufficient documentation to support its claim. The Intermediary's adjustment disallowing these costs due to lack of documentation is affirmed.

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

The Board finds that the Provider failed to provide sufficient documentation to support its claim. The Intermediary's adjustment disallowing these costs due to lack of documentation is affirmed.

Issue 11. Was the Intermediary's adjustment to additional accounts payable/capital related costs proper?

The Board finds that the Provider failed to provide sufficient documentation to support its claim. The Intermediary's adjustment disallowing these costs due to lack of documentation is affirmed.

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

The Board finds that the Provider failed to provide sufficient documentation to support its claim. The Intermediary's adjustment disallowing these costs due to lack of documentation is affirmed.

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

The Board finds that the Provider failed to provide sufficient documentation to support its claim. The Intermediary's adjustment disallowing these costs due to lack of documentation is affirmed.

Issue 14. Was the Intermediary's adjustment to home office costs proper? (Provider's Issue 15)

The Board finds that the Provider failed to provide sufficient documentation to support its claim. The Intermediary's adjustment disallowing these costs due to lack of documentation is affirmed.

Issue 15. Were the Provider's requests for the inclusion of costs incurred in settling the cost report after termination from the Medicare program proper? (Provider's Issue 14)

The Board finds that these termination costs should have been 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

DATE: September 19, 2007

FOR THE BOARD:

Suzanne Cochran, Esquire
Chairperson