PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

ON THE RECORD
2007-D70

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, 1995

CASE NO.: 00-3349

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[1] The issue numbers in the Intermediary and Provider position papers are not the same. For simplicity, this decision utilizes the issue numbers from the Intermediary's position paper and notes the corresponding issue number in the Provider's position paper in parentheses.

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MEDICARE STATUTORY AND REGULATORY BACKGROUND

This is a dispute over the amount of Medicare reimbursement due a provider of medical services.

The Medicare program was established to provide health insurance to the aged and disabled. 42 U.S.C. §§1395-1395cc. The Centers for Medicare and Medicaid Services (CMS), formerly the Health Care Financing Administration (HCFA), is the operating component of the Department of Health and Human Services (DHHS) charged with administering the Medicare program. CMS' payment and audit functions under the Medicare program are contracted out to insurance companies known as fiscal intermediaries. Fiscal intermediaries determine payment amounts due the providers under Medicare law and under interpretive guidelines published by CMS. See, 42 U.S.C. §1395(h), 42 C.F.R. §§413.20(b) and 413.24(b).

At the close of its fiscal year, a provider must submit a cost report to the fiscal intermediary showing the costs it incurred during the fiscal year and the 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 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. 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, 1995 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. Currently, Palmetto Government Benefits Administrators is the Intermediary. Both the entities will be referred to as the Intermediary. 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 an NPR issued on June 27, 2000. The Provider timely appealed the disallowances to the Board and met the jurisdictional requirements of 42 C.F.R. §405.1831-405.1841.

The Board held a live in person hearing for this case on November 7, 2001. Because of concerns raised at the in person 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 requested that additional audit work be performed and allowed the Provider to submit additional documentation. At the Board's request, the Intermediary completed a review of the additional documentation, and on January 30, 2003, submitted its report. The Intermediary proposed no adjustments based on its reaudit. 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. See Board letter dated January 28, 2005. In the supplemental position paper, the Intermediary was asked to indicate for any costs disallowed after the reaudit, why the initial audit adjustment was made, what additional documentation was submitted by the Provider, and why the additional documentation was not sufficient to reverse the adjustment. After receipt of the Intermediary's supplemental position paper, the Provider was allowed to submit a brief in response to the Intermediary revised positions to the Board. 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 Bernard M. Talbert, Esquire, and Eileen Bradley, Esquire, of Blue Cross Blue Shield Association.

1. Did the Intermediary improperly reopen the cost report?

FACTS:

The Provider filed its Medicare cost report for FYE December 31, 1995 on March 31, 1996. The Intermediary issued its NPR for fiscal year 1995 on June 27, 2000. The NPR showed a balance due the program of $3,091,365.

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, the Intermediary's failure to issue a timely NPR results in the Provider's as-filed 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 the fiscal year ended December 31, 1995 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 12 months following the filing of a cost report results in the as-filed cost report becoming a 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 an as-filed cost report automatically becomes a final intermediary determination if the intermediary does not issue an NPR within 12 months of receipt of the cost report. 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, 1995 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 three-year limitation is without merit.

2. 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 with its original cost report, but the Intermediary failed to conduct a review of the documentation that was available at the facility; therefore, there is no basis to disallow these costs.

The Intermediary initially denied the Provider's Medicare bad debts due to lack of supporting documentation. The Provider did not submit any additional documentation; therefore, the Intermediary did not propose any revision to its initial adjustment. See Exhibit I-6 at 5.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

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

There was no evidence in the record to determine whether the Provider furnished sufficient documentation to support its bad debt claims. The Board finds that without proper documentation, the Provider's claim for bad debts is not supported, and the Intermediary's adjustment was proper.

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

FACTS:

The administrative and general (A&G), physical therapy, speech therapy and occupational therapy salaries were accumulated on the books of the home office and allocated to the Provider. The Intermediary initially denied these costs due to lack of documentation. After review of the additional documentation supplied by the Provider, the Intermediary continued to deny the costs because the Provider did not furnish support for the basis of the allocation.

PARTIES' CONTENTIONS:

The Provider asserts that in order to audit salaries, the Intermediary is required to test the Provider's payroll system, use the employee's earning register to verify salaries and request and review appropriate documentation. The Provider claims that in order to verify total paid salaries, the Intermediary requested copies of W-2s/1099s, contracts, employee job titles, the number of hours each employee worked and a schedule of employees related to owners/shareholders. However, the Intermediary disallowed the claimed salaries, citing a lack of documentation. The Intermediary also claims that the Provider failed to provide requested W-2s, and that the salaries reported on the 1099 and 941 forms did not reconcile to the 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 maintains that

documentation needed to verify the salaries claimed was available at its facility and that the Intermediary should have visited the facility to audit these costs rather than expecting the Provider to retrieve, copy and mail the documentation to the auditor's office in Miami.

The Intermediary states that it reviewed the additional documentation submitted by the Provider which consisted of W-2 forms, payroll tax returns and copies of checks paying certain taxes. Intermediary's Supplemental Position Paper at 15. The Intermediary states that the W-2s provided were illegible, and there was no year-to-date payroll register or copies of checks. In addition, the Intermediary states there was no detailed general ledger to which invoices could be traced. The Intermediary did not allow any additional salary 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 salaries at issue were accumulated on the books of the Provider's home office and allocated to the Provider. The Board finds that the Provider's failure to submit W-2s or 941s is not dispositive of the issue. 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 necessarily be sufficient to support the allocation of these costs even if it had been furnished. Instead, the Provider should have furnished a detailed accounting of the allowable services and associated hours rendered by employees to each provider in support of the allocation. Absent this detailed documentation, the Intermediary's disallowance of these costs was proper.

4. through 7. Were the Intermediary's adjustments to travel expenses – speech therapy, physical therapy, occupational therapy and administrative and general proper?

FACTS:

The Provider claimed travel expenses related to speech therapy, physical therapy, occupational therapy and administrative and general on its cost report. The Intermediary initially denied these costs due to lack of documentation. After review of the additional documentation supplied by the Provider, the Intermediary continued to deny the costs because the documentation provided was inadequate to support the claim.

PARTIES' CONTENTIONS:

The Provider claims that its travel costs 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, had no basis to disallow these costs.

The Intermediary reviewed additional documentation supplied by the Provider but did not allow any additional costs. The Intermediary states the information was inadequate because many of the documents provided were illegible, and there were several credit card invoices without corresponding expense reports or receipts; therefore, it was impossible to tell whether the expense was for a business purpose. The Provider also failed to furnish a detailed general ledger to which the invoices could be traced. Intermediary's Supplemental Position Paper at 16-19.

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 there is insufficient documentation in the record to support the Provider's claim for these costs; therefore, the Intermediary's adjustments due to lack of documentation were proper.

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

BACKGROUND:

The Provider claimed auto expenses that the Intermediary initially denied due to lack of documentation. After reviewing the additional documentation supplied by the Provider, the Intermediary continued to deny the costs because none of the costs could be traced to the general ledger, and the documentation was insufficient to determine whether the costs were related to patient care. 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.

The Intermediary indicates that the Provider did not submit any additional documentation. Therefore, the Intermediary did not propose any change to its original adjustment.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

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

There was no evidence in the record to support the Provider's claim for auto expense. The Board finds that without proper documentation, the Provider's claim for this expense is not supported, and the Intermediary's adjustment was proper.

9. through 11. Were the Intermediary's adjustments to contracted services – occupational therapy, speech therapy and administrative and general proper?

BACKGROUND:

The Provider claimed contracted services costs which the Intermediary initially denied due to 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 due to incomplete documentation and an inability to trace costs to the general ledger. See Intermediary's Supplemental Position Paper at 19-21.

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 it consisted of invoices without corresponding checks or checks without the corresponding invoices. The Intermediary states that it needed complete invoices and copies of the corresponding checks demonstrating that the Provider had paid the invoices in order for the costs to be allowed. This information was not furnished by the Provider. In addition, the Intermediary never received a detailed general ledger to which the invoices for contracted services could be traced. Therefore, the Intermediary did not propose any change to its original adjustments.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

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

There was no evidence in the record to support the Provider's claim for the costs of contracted services. The Board finds that without proper documentation, the Provider's claim for these expenses is not supported, and the Intermediary's adjustments were proper.

12. Was the Intermediary's adjustment to consulting expenses proper?

BACKGROUND:

The Provider claimed consulting expenses which the Intermediary initially denied due to 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 due to insufficient documentation and an inability to trace costs to the general ledger. See Intermediary's Supplemental Position Paper at 22.

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 it consisted of invoices without the corresponding checks or checks without the corresponding invoices. The Intermediary states that it needed complete invoices and copies of the corresponding checks demonstrating that the Provider paid the invoices in order for the costs to be allowed. This information was not furnished by the Provider. In addition, the Intermediary never received a detailed general ledger to which the invoices for consulting expenses could be traced. Therefore, the Intermediary did not propose any change to its original adjustment.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

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

There was no evidence in the record to support the Provider's claim for consulting expenses. The Board finds that without proper documentation, the Provider's claim for these expenses is not supported, and the Intermediary's adjustment was proper.

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

BACKGROUND:

The Intermediary disallowed accounting costs due to lack of supporting documentation. The Intermediary reviewed additional documentation and continued to deny the costs for lack of documentation. See Intermediary's Supplemental Position Paper at 22-23.

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 it consisted of invoices without the corresponding checks or checks without the corresponding invoices. The Intermediary states that it needed complete invoices and copies of the corresponding checks demonstrating that the Provider paid the invoices in order for the costs to be allowed. This information was not furnished by the Provider. In addition, the Intermediary never received a detailed general ledger to which the invoices for consulting expenses could be traced. Therefore, the Intermediary did not propose any change to its original adjustment.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

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

There was no evidence in the record to support the Provider's claim for accounting expenses. The Board finds that without proper documentation, the Provider's claim for these expenses is not supported, and the Intermediary's adjustment was proper.

14. Was the Intermediary's adjustment to legal fees proper?

BACKGROUND:

The Intermediary disallowed legal fees due to lack of supporting documentation. The Intermediary reviewed additional documentation and continued to deny the costs for lack of documentation. Intermediary's Supplemental Position Paper at 23.

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 was incomplete in that invoices were submitted without proof of payment. The Intermediary states that it needed complete invoices and copies of the corresponding checks demonstrating that the Provider paid the invoices in order for the costs to be allowed. This information was not furnished by the Provider. In addition, the Intermediary never received a detailed general ledger to which the invoices for legal fees could be traced. Therefore, the Intermediary did not propose any change to its original adjustment.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

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

There was no evidence in the record to support the Provider's claim for legal fees. The Board finds that without proper documentation, the Provider's claim for these costs is not supported, and the Intermediary's adjustment was proper.

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

BACKGROUND:

The Provider claimed the costs of supplies related to administrative and general, physical therapy, occupational therapy and speech therapy 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 of insufficient documentation. See Intermediary's Supplemental Position Paper at 24.

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 it was incomplete in that invoices were submitted without the corresponding check copies. The Intermediary states that it needed complete invoices and copies of the corresponding checks showing that the Provider paid the invoices in order for the costs to be allowed. This information was not furnished by the Provider. In addition, the Intermediary never received a detailed general ledger to which the invoices for supply costs could be traced. Therefore, the Intermediary did not propose any change to its original adjustment.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

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

There was no evidence in the record to support the Provider's claim for the cost of supplies. The Board finds that without proper documentation, the Provider's claim for these costs is not supported, and the Intermediary's adjustment was proper.

16. Was the Intermediary's adjustment to seminar expense proper?

BACKGROUND:

The Provider claimed seminar expenses which the Intermediary initially denied due to lack of documentation. The Intermediary did not allow any additional costs because no additional documentation was submitted by the Provider for this issue. See Intermediary's Supplemental Position Paper at 25.

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; therefore, the Intermediary did not propose any change to its original adjustment.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

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

There was no evidence in the record to support the Provider's claim for seminar expenses. The Board finds that without proper documentation, the Provider's claim for these expenses is not supported, and the Intermediary's adjustment was proper.

17. 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 continued to find the documentation incomplete. See Intermediary's Supplemental Position Paper at 26.

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 was incomplete. The Provider submitted telephone invoices, but there were few corresponding check copies to prove payment. On the invoices furnished, the Provider made allocations to other entities but did not show the basis of the allocations. Therefore, it was impossible for the Intermediary to verify the entity to which the costs should be allocated. In addition, the Intermediary never received a detailed general ledger to which the invoices for telephone costs could be traced. Therefore, the Intermediary did not propose any change to its original adjustment.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

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

There was no evidence in the record to support the Provider's claim for telephone expenses. The Board finds that without proper documentation, the Provider's claim for these expenses is not supported, and the Intermediary's adjustment was proper.

18. Was the Intermediary's adjustment to administrative dues and subscription expense proper?

BACKGROUND:

The Provider claimed dues and subscription expenses which the Intermediary initially denied due to lack of documentation. After its review of additional documentation supplied by the Provider, the Intermediary continued to deem the documentation incomplete and the costs non-allowable. See Intermediary's Supplemental Position Paper at 26-27.

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 was incomplete. The Intermediary indicates that only one invoice was adequately documented; however, the cost related to lobbying, which is a non-allowable cost. Therefore, the Intermediary did not propose any change to its original adjustment.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

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

There was no evidence in the record to support the Provider's claim for allowable dues and subscription expenses. The Board finds that without proper documentation, the Provider's claim for these expenses is not supported, and the Intermediary's adjustment was proper.

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

BACKGROUND:

The Provider claimed the cost of office supplies which the Intermediary initially denied due to lack of documentation. After its review of additional documentation supplied by the Provider, the Intermediary continued to deem the documentation incomplete and the costs non-allowable. See Intermediary's Supplemental Position Paper at 28.

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 was insufficient because no corresponding checks were submitted with the invoices. Also, the Intermediary never received a detailed general ledger to which the invoices could be traced. The Intermediary also disallowed invoices that had delivery addresses other than the Provider's and invoices that indicated that they were to be repaid by others. Id. Therefore, the Intermediary did not propose any change to its original adjustment.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board, after consideration of the Medicare law and guidelines, the parties' contentions, and evidence presented, finds and concludes as follows:
There was no evidence in the record to support the Provider's claim for the cost of office supplies. The Board finds that without proper documentation, the Provider's claim for these cost is not supported, and the Intermediary's adjustment was proper.

20. Was the Intermediary's adjustment to rent expense - building and equipment proper?

BACKGROUND:

The Intermediary initially denied rental expense for buildings and equipment 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 was incomplete. See Intermediary's Supplemental Position Paper at 29.

PARTIES' CONTENTIONS:

The Provider claims that it is routine for outpatient therapy providers (OPTs) to pay rent to skilled nursing facilities for the space in which they provide therapy services and for the use of needed equipment. The Provider states that the Intermediary reviewed the substance of these transactions in detail in 1992, and the Intermediary has no basis upon which to deny these allowable costs.

The Intermediary indicates that the lease documents supplied by the Provider did not pertain to the fiscal period at issue. The Intermediary did not allow costs paid to nursing

homes for which there was no documented lease agreement. The Intermediary also indicated that it never received a detailed general ledger to which invoices could be traced. Id. The Intermediary proposed no change to the original adjustment denying these costs.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

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

There was no evidence in the record to support the Provider's claim for rental expenses for building and equipment. The Board finds that without proper documentation, the Provider's claim for these expenses is not supported, and the Intermediary's adjustment was proper.

21. Was the Intermediary's adjustment to maintenance agreement expense proper?

BACKGROUND:

The Intermediary initially disallowed expenses related to a maintenance agreement due to lack of documentation. The Intermediary did not allow any additional costs because the Provider did not submit additional documentation for this issue. See Intermediary's Supplemental Position Paper at 29.

PARTIES' CONTENTIONS:

The Provider maintains that the fact that these costs are listed on the originally filed trial balance is sufficient documentation to support these costs. In its initial audit the Intermediary rejected this explanation and eliminated all of the maintenance costs claimed by the Provider. Since no additional documentation was furnished during the subsequent review, the disallowance remains unchanged. Id.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

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

There was no evidence in the record to support the Provider's claim for maintenance agreement expenses. The Board finds that without proper documentation, the Provider's claim for these costs is not supported, and the Intermediary's adjustment was proper.

22. Was the Intermediary's adjustment to depreciation expense proper?

See Issue #30.

23. Was the Intermediary's adjustment to recruiting expenses – Rehab Resources proper?

BACKGROUND:

The costs for recruiting fees paid to Rehab Resources was accumulated on the home office's books 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 lack of disclosure of the relatedness of the party billing the Provider for these services, Rehab Resources. Exhibit P-23(a). The Intermediary continued to deny the costs because the Provider did not provide any additional documentation to support its claim. See Intermediary's Supplemental Position Paper at 30.

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 it with assistance during the transition period, 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 asserts 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.

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 related. Exhibit P-104 at 13-16.

The Intermediary denied the recruitment costs due to lack of documentation and an undisclosed related party issue. The Intermediary indicates that the Provider did not supply any additional documentation to support its claim; therefore, the Intermediary did not allow any recruiting 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 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-23 at 1. Based on this acknowledgement, the Board finds that the parties were related and that disallowance 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 a list of costs that should be approved if the Board finds that the parties are related. See Exhibit P-104 at 13 -16. The Board found no indication in the record that the Intermediary reviewed any of the recruiting costs claimed by the Provider for reasonableness or accuracy. Neither did

the Intermediary review the basis upon which PTK allocated recruiting costs to each of the entities in the chain, including the Provider. The Board, therefore, remands this issue to the Intermediary for a review of the actual costs of the related party for which there is adequate documentation to support the costs and their allocation to the Provider.

24. through 29. Were the Intermediary's adjustments to total and other charges for physical therapy, occupational therapy and speech therapy services proper?

BACKGROUND:

The Intermediary made adjustments to reconcile Medicare therapy charges per the as-filed cost report to the Provider Statistical and Reimbursement Report (PS&R). Since total therapy charges come from the Provider's records and are not impacted by this reconciliation, decreases in Medicare charges precipitate an increase in "other charges." The concomitant increase in other charges usually represents denied claims for therapy services. Since the Provider did not furnish any additional documentation, the Intermediary did not revise its original adjustments.

PARTIES' CONTENTIONS:

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

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

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

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

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

30. Were the Provider's requests for additional costs for depreciation and contracted services-physical therapy proper?

FACTS:

The Provider did not receive credit for depreciation expense in its 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. The Intermediary states that since the Provider did not claim the costs related to contracted physical therapy services in its as-filed cost report, the costs cannot be appealed. The Intermediary suggests that a request for reopening is the appropriate way to seek reimbursement for unclaimed costs that can be supported by adequate documentation. See Intermediary's Supplemental Position Paper at 33.

PARTIES' CONTENTIONS:

The Provider claims that during the 1992 audit, which was completed in 1995, the Intermediary developed a depreciation schedule for the Provider. The Provider states this schedule was developed after it submitted cost reports for fiscal years 1993 through 1995. The Provider asserts that the Intermediary should have relied upon prior year audit workpapers and corrected the depreciation expense for this year.

The Provider contends that it complied with the Intermediary's request for information to support its costs for contracted physical therapy services, but the Intermediary rejected the documentation as inadequate without conducting an adequate field audit.

The Intermediary states that the depreciation schedule prepared and approved by the Intermediary in previous years would be reviewed and the appropriate depreciation allowed. See Intermediary's Supplemental Position Paper at 33.

The Intermediary notes that the Provider presented several spread sheets as support for inclusion of contracted services for physical therapy. Id. The Intermediary contends that adequate supporting documentation for the spread sheet would also have to be provided to allow any additional costs. Absent any additional documentation, 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 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.

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

DECISIONS AND ORDERS:

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

The Board finds that the Provider's as-filed December 31, 1995 cost report did not become a final Intermediary 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.

2. Was the Intermediary's adjustment to bad debts proper? (Provider Issue 2)

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

3. Was the Intermediary's adjustment to salaries proper? (Provider Issue 3)

The Board found the documentation provided insufficient to support the accrual and allocation of these costs to this Provider. The Intermediary adjustment is affirmed.

4. through 7. Were the Intermediary's adjustments to travel expense – speech therapy, physical therapy, occupational therapy and administrative and general proper? (Provider Issues 4 through7)

The Board finds that the Provider failed to provide any documentation to support its claims. The Intermediary's adjustments disallowing these costs due to lack of documentation are affirmed.

8. Was the Intermediary's adjustment to auto expense proper? (Provider Issue 8)

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

9. through 11. Were the Intermediary's adjustments to contracted services – occupational therapy, speech therapy and administrative and general proper? (Provider Issues 9 through 11)

The Board finds that the Provider failed to provide any documentation to support its claimed costs for these services. The Intermediary's adjustments disallowing these costs due to lack of documentation are affirmed.

12. Was the Intermediary's adjustment to consultant expenses proper? (Provider Issue 12)

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

13. Was the Intermediary's adjustment to accounting expense proper? (Provider Issue 13)

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

14. Was the Intermediary's adjustment to legal fees proper? (Provider Issue 14)

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

15. Was the Intermediary's adjustment to supply expenses proper? (Provider Issue 15)

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

16. Was the Intermediary's adjustment to seminar expense proper? (Provider Issue 16)

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

17. Was the Intermediary's adjustment to telephone expense proper? (Provider Issue 17)

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

18. Was the Intermediary's adjustment to administrative dues and subscription expense proper? (Provider Issue 18)

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

19. Was the Intermediary's adjustment to office supply expense proper? (Provider Issue 19)

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

20. Was the Intermediary's adjustment to rent expense – building and equipment proper? (Provider Issue 20)

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

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

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

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

This issue is addressed in issue 30 below.

23. Was the Intermediary's adjustment to recruiting expenses – Rehab Resources proper? (Provider Issue 23)

The Board finds that the Intermediary did not review the Provider's recruiting costs for reasonableness, accuracy, or the allocation of these related party costs among the 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 are adequate documentation.

24. through 29. Were the Intermediary's adjustments to total and other charges – physical, occupational and speech therapy services proper? (Provider Issue 24 through 29)

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

30. Were the Provider's requests for additional costs for depreciation and contracted services - physical therapy proper? (Provider Issues 25 and 26)

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 expenses. With respect to the other costs, the Board notes that the Provider did not claim them and the Intermediary did not make any audit adjustments. Therefore, the Board finds that they are not subject to the Board's review.

BOARD MEMBERS PARTICIPATING:

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

DATE: September 18, 2007

FOR THE BOARD:

Suzanne Cochran, Esquire
Chairman