Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

AUDIT OF COSTS CLAIMED ON THE MEDICARE COST REPORT BY THE PRINCE WILLIAM ANNABURG MANOR FOR FISCAL YEAR ENDED JUNE 30, 1998

JANET REHNQUIST
INSPECTOR GENERAL

MARCH 2002
A-03-00-00215

DEPARTMENT OF HEALTH & HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL
OFFICE OF AUDIT SERVICES
150 S. INDEPENDENCE MALL WEST
SUITE 316
PHILADELPHIA, PENNSYLVANIA 19106-3499

March 7, 2002

Common Identification Number: A-03-00-00215

Ms. Carol E. Mullins
Administrator
Prince William Annaburg Manor
9201 Maple Avenue
Manassas, Virginia 20110

Dear Ms. Mullins:

Enclosed are two copies of the United States Department of Health and Human Services (HHS), Office of Inspector General (OIG), Office of Audit Services' (OAS) final report entitled, "Audit of Costs Claimed on the Medicare Cost Report, by the Prince William Annaburg Manor for Fiscal Year Ended June 30, 1998."

Final determination as to actions taken on all matters reported will be made by the HHS action official named below. We request that you respond to the HHS action official within 30 days from the date of this letter. Your response should present any comments or additional information that you believe may have a bearing on the final determination.

In accordance with the principles of the Freedom of Information Act (5 U.S.C. 552, as amended by Public Law 104-231), OIG, OAS reports issued to the Department's grantees and contractors are made available to members of the press and general public to the extent information contained therein is not subject to exemptions in the Act which the department chooses to exercise (See 45 CFR Part 5.)

To facilitate identification, please refer to Common Identification Number A-03-00-00215 in all correspondence relating to this report.

Sincerely yours,

David M. Long

David M. Long
Regional Inspector General for
Audit Services

Enclosures - as stated

Direct Reply to HHS Action Official:

Mr. Joe Tilghman
Regional Administrator
Centers for Medicare and Medicaid Services
Midwestern Consortium
Kansas City Federal Office
601 East 12th Street
Kansas City, Missouri 64106

EXECUTIVE SUMMARY

The purpose of our audit was to determine whether costs claimed by Prince William Annaburg Manor (PWAM), formerly known as the Annaburg Manor Nursing Home, a Medicare skilled nursing facility (SNF) provider, on its Fiscal Year (FY) 1998 Medicare cost report were in accordance with Medicare reimbursement requirements. Our audit disclosed that $1,582,079 or about 13 percent of the total claimed by PWAM on its FY 1998 Medicare cost report was claimed in violation of Medicare regulations. These unallowable cost were caused by the PWAM not applying the proper Medicare regulations. We recommend that Mutual of Omaha, the fiscal intermediary (FI), adjust the FY 1998 Medicare cost report for the $1,582,079 improperly claimed, and insure that PWAM strengthens its procedures to preclude claiming unallowable cost.

Background

During the period covered by our audit Medicare generally reimbursed SNFs on a reasonable cost basis as determined under principles established in the law and regulations. In order to determine its reasonable costs, providers are required to submit annual cost reports. The SNFs were receiving interim payments that represented estimated actual costs. The cost report was used to derive the actual reimbursable costs less the interim payments to arrive at a final settlement.

The Centers for Medicare and Medicaid Services (CMS), formerly the Health Care Financing Administration, administers the Medicare program and designates certain FIs to perform various functions, such as processing Medicare claims, performing cost report audits, and providing consultative services to assist SNFs as providers.

Objective

The objective of our audit was to determine if PWAM claimed its costs on the Medicare cost report for FY 1998 in compliance with Medicare reimbursement requirements.

We conducted our audit in accordance with generally accepted government auditing standards. As part of our audit, we obtained an understanding of the internal control structure relative to the Medicare cost report. However, the objective of this audit did not require an assessment of these internal controls. Our audit did not include a medical review of Medicare claims submitted during FY 1998. Accordingly we are not providing an opinion on the necessity or quality of SNF services rendered. We performed the audit at PWAM located in Manassas, Virginia during the period August through November 2000.

Summary of Findings

Our audit disclosed that $1,582,079 or about 13 percent of the total $12,401,160 claimed by PWAM on its FY 1998 Medicare cost report were not allowable under Medicare regulations. The following costs on the FY 1998 Medicare cost report were not allowable.

	Total Cost Claimed	Disallowed
Therapy	$1,386,131	$1,386,131
Personal laundry & Overhead	332,801	80,539
Administrative & Maintenance	339,719	76,971
Administrative & General	1,340,449	15,804
Vending machine income	(1)	7,000
Bad Debts	24,390	1,995
Beauty Shop	(2)	13,639
Total	$3,423,490	$1,582,079

(1) This is not a "Cost item". PWAM should have offset vending machine income, which is done now in the FY 1998 Medicare cost report.
(2) The "Beauty Shop" is a cost center that is not related to patient care according to Medicare regulations and is setup as a non-reimbursable cost center in the Medicare cost report.

Recommendations

We recommend that the FI instruct PWAM to strengthen its procedures to ensure that only allowable costs are included on the Medicare cost report. We also recommend that the FI adjust the FY 1998 Medicare cost report to reflect the $1,582,079 in unallowable cost disclosed during our audit and recover overpayments.

The draft report was issued on July 31, 2001 to PWAM for comments. In response to the draft report, the PWAM did not agree with several of our findings and recommendations. Basically, the PWAM believed that documentation of payroll records should be acceptable as support for therapy cost claimed; personal laundry improperly claimed should be removed from the cost report via a revenue offset; and regarding maintenance cost claimed, it did not understand how the finding was developed. We have taken the comments into consideration and have responded accordingly.

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INTRODUCTION

The purpose of our audit was to determine whether costs claimed by PWAM on its FY 1998 Medicare cost report were in accordance with Medicare reimbursement requirements. Our audit disclosed that $1,582,079 or about 13 percent of the total claimed by PWAM on its FY 1998 Medicare cost report were claimed in violation of Medicare regulations. These unallowable cost were caused by PWAM not applying the proper Medicare regulations. We recommend that the FI adjust the FY 1998 Medicare cost report for the $1,582,079 improperly claimed, and insure that PWAM strengthens its procedures to preclude claiming unallowable costs.

BACKGROUND

During the period of our audit Medicare generally reimbursed SNFs on a reasonable cost basis as determined under principles established in the law and regulations. In order to determine its reasonable costs, providers are required to submit annual cost reports. The SNFs are paid on an interim basis (that represents the estimated actual costs, based upon its billings to Medicare). The cost report is used to derive the actual reimbursable costs less the interim payments to arrive at a final settlement. Costs are classified on the cost report as either routine or ancillary.

Routine services are generally those services included by the provider in a daily service sometimes referred to as the "room and board" charge. Included in routine services are the regular room, dietary and nursing services, minor medical and surgical supplies, and use of certain equipment and facilities for which a separate charge is not customarily made. Ancillary services are those services directly identifiable and billable to individual patients, such as laboratory, radiology, drugs, medical supplies, and therapies.

Medicare pays its portion of a provider's reasonable costs based upon an apportionment between program beneficiaries and other patients so that Medicare's share is determined on a basis of a ratio of Medicare patient days to total patient days. Section 1888 of the Social Security Act limits Medicare reimbursement for SNF's routine costs to 112 percent of the mean operating costs of other similar SNFs. Thus, Medicare does not share in routine costs exceeding the Federal limit, unless the provider applies for and receives an exception from the CMS. Ancillary costs are determined based on the ratio of total costs to total charges and multiplied by Medicare charges to arrive at the Medicare cost.

The CMS administers the Medicare program and designates certain FIs to perform various functions, such as processing Medicare claims, performing cost report audits, and providing consultative services to assist SNFs as providers. The CMS's policies and procedures of reimbursement are outlined in its provider reimbursement manuals.

Medicare Regulations and Provider Reimbursement Principles

During our audit period SNFs were reimbursed for reasonable costs subject to routine cost limitations. Cost principles governing reasonable, allowable and allocable costs are detailed in the Provider Reimbursement Manual (PRM-I and II). The PRM-I states, in part:

> "...reasonable cost includes all necessary and proper costs incurred in rendering the services..."

Further the PRM-I states:

> "Implicit in the intention that actual costs be paid to the extent they are reasonable is the expectation that the provider seeks to minimize its costs and that its actual costs do not exceed what a prudent and cost conscious buyer pays for a given item or service."

Also included in the PRM is the requirement that allowable cost be related to patient care. The PRM states:

> "Costs not related to patient care are costs, which are not appropriate or necessary and proper in developing and maintaining the operation of patient care and facilities. Costs which are not necessary include costs which usually are not common or accepted occurrences in the field of the provider's activity."

The essence of the reimbursement principle under Medicare is stipulated in PRM-I, Section 2103 "Prudent-Buyer Principle":

> "The prudent and cost conscious buyer not only refuses to pay more than the going price for an item or service, he/she also seeks to economize by minimizing cost..."

OBJECTIVES, SCOPE AND METHODOLOGY

The purpose of our audit was to determine if PWAM claimed its costs on the Medicare cost report for FY 1998 in compliance with Medicare reimbursement guidelines.

We conducted our audit in accordance with generally accepted government auditing standards. As part of our audit, we obtained an understanding of the internal control structure relative to the Medicare cost report. However, the objective of this audit did not require an assessment of these internal controls. To accomplish our audit objective we:

- reviewed Medicare cost reimbursement criteria;
- reviewed the FI current audit files;
- analyzed the PWAM FY 1998 Medicare cost report;

- reviewed supporting documentation related to costs claimed on PWAM's FY 1998 Medicare cost report to determine if cost claimed were in compliance with Medicare regulations; and,
- interviewed the PWAM officials and the cost report preparers.

Our audit did not include a medical review of Medicare claims submitted during FY 1998. Accordingly we are not providing an opinion on the necessity or quality of SNF services rendered. We performed the fieldwork at PWAM located in Manassas, Virginia, during the period August through November 2000.

By letter dated September 27, 2001 the PWAM responded to our draft report. The PWAM generally disagreed with our findings. The PWAM response is presented as an appendix to this report. In addition, we have provided our response to the comments in each section of this report.

FINDINGS AND RECOMMENDATIONS

Our audit disclosed that $1,582,079 or about 13 percent of the total $12,401,160 claimed by PWAM on its FY 1998 Medicare cost report were in violation of Medicare regulations. The following costs were unallowable:

	Total Cost	Disallowed Claimed
Therapy	$1,386,131	$1,386,131
Personal laundry & Overhead	332,801	80,539
Administrative & Maintenance	339,719	76,971
Administrative & General	1,340,449	15,804
Vending machine income	(1)	7,000
Bad Debts	24,390	1,995
Beauty Shop	(2)	13,639
Total	$3,423,490	$1,582,079

(1) This is not a "Cost item". PWAM should have offset vending machine income, which is done now in the FY 1998 Medicare cost report.
(2) The "Beauty Shop" is a cost center that is not related to patient care according to Medicare regulations and is setup as a non-reimbursable cost center in the Medicare cost report..

THERAPY ($1,386,131)

The Prince William Hospital (PWH) is a related organization under the same umbrella of Prince William Health System, also known as UNICARE Health System. The PWH had been rendering therapy services to PWAM patients such as Physical, Occupational, Speech and Respiratory/Oxygen therapy for over 10 years. The fees for the therapy services were based on

the actual costs of therapists' salaries and other administrative costs with a 10 percent profit margin, payable to PWH on a monthly basis. However, at the end of the year, the therapy costs were adjusted to the actual costs of the therapists salaries, based on number of hours of services rendered to PWAM which also included the applicable overhead costs (reflected in PWH's Medicare cost report). This was due to the fact that Medicare regulations allow only the actual costs incurred by the related organization and not any profit element.

The PWH had billed based on the therapist hours worked. However, PWAM did not have auditable documentation to substantiate the number of actual therapy hours billed to PWAM. Thus, we were unable to verify the basic supporting data of the therapy costs billed (which was based on the actual therapy hours worked at PWAM) to PWAM.

The PWAM is responsible for maintaining documentation to support costs claimed in the cost report pursuant to Section 1417 A. PRM-I that stipulates in part:

> "A provider must maintain sufficient data in its records to support the statements submitted with its cost report, and **the data must be reflected in a manner so as to provide an adequate audit trail...**Where a provider does not maintain records which are sufficiently complete to determine the reasonable cost of the services in accordance with the provisions of this chapter, **no payment can be made for these services in accordance** with sections 1815 and 1833 (e) of the Social Security Act." (Emphasis added)

The PWAM did not meet the criteria of maintaining adequate time records of the therapists who actually rendered the therapy services at it's site. The therapy costs of $1,386,131, as detailed below, are unallowable due to lack of supporting documentation per Medicare regulations:

Therapy Services	**Costs Claimed**
Physical	$322,457
Occupational	268,169
Speech	104,288
Respiratory	641,217
Total	$1,386,131

PWAM Comments

The PWAM believed that documentation provided in the form of payroll records for therapists assigned by the PWH were sufficient to support the therapy salaries claimed at PWAM. The PWAM furnished four categories of documents which it believes support the therapy services provided to the PWAM patients. The following documents were provided as support:

payroll records from PWH which specifically state the name of each therapist providing services; monthly invoices prepared from each therapist's daily time sheets detailing the number of therapy hours; a sample PWH payroll report generated from the individual therapist's daily time sheets indicating the name of the therapist and the date and total number of hours worked at PWAM; and, a sample monthly therapy log containing the names of Medicare patients, the type of therapy provided, the number of therapy units, and the date on which such services were provided.

The PWAM also identified a decision by the Provider Reimbursement Review Board (PRRB) that it believes also provided support for the documentation provided. Specifically, in Desert Springs Hospital v. Aetna, the fiscal intermediary denied Medicare rei-mbursement to a SNF for therapy services furnished to facility residents under arrangement with a vendor, concluding that the SNF did not adequately document its cost. The PRRB reversed this determination and authorized reimbursement for those periods in which the vendor maintained "daily" time sheets.

OAS Response

Payroll records reviewed did not specifically identify the actual hours worked at the PWAM by specific therapy personnel. Actual sign in sheets or daily time logs completed by therapy personnel should be used to support therapy hours claimed. Neither the PWH or PWAM provided "daily time sheet" documentation to support actual hours claimed for therapy services provided.

PERSONAL LAUNDRY & OVERHEAD ($80,539)

The PWAM improperly claimed $80,539 in patient personal laundry costs on the FY 1998 Medicare cost report. In 1997 the PWAM suspended doing laundry at its premises and contracted with PWH to provide all laundry services. According to the Medicare regulations, all patient's personal laundry expenditures must be removed from the applicable Medicare cost report. Section 2106.1 of the PRM states:

> "General--The full costs of items or services...which are furnished solely for the personal comfort of the patients (full costs include costs both directly associated with personal comfort items or services plus an appropriate share of indirect costs) are not includable in allowable costs of providers under the Medicare program."

PWAM Comments

The PWAM did not dispute that personal laundry costs of its Medicare residents should not be reimbursed by Medicare. However, PWAM stated that because the costs and space associated with personal laundry use cannot be adequately separated from the institutional laundry functions, the costs associated with the personal laundry were appropriately removed from the cost report via a revenue offset. Furthermore, the PWAM stated that the proper way to account for personal laundry costs was as a revenue offset equal to funds received for the personal

laundry. This amount, $14,294, represented revenue received exclusively from private-pay patients and was obtained from the working trial balance of PWAM.

OAS Response

The personal laundry unallowable cost remain at $80,539 which includes salaries and overhead cost claimed by PWAM. The cost identified as salaries and overhead for laundry expense in the PWAM trial balance must be removed from the cost report. The fact that the PWAM could not separate personal laundry costs from institutional laundry costs does not permit it from deviating from Medicare requirements.

ADMINISTRATIVE & MAINTENANCE ($76,971)

The PWAM improperly claimed $76,971 of administration and maintenance cost for the Caton Merchant House (CMH). During a tour of the nursing home, we found that CMH, (a related party, that houses retired people) is attached to the PWAM premises and received services such as meals, accounting/administrative, maintenance and other items. There was no allocation of overhead costs as required by Medicare regulations. Consequently, the overhead costs applicable to the CMH for these services have been included in the FY 1998 Medicare cost report. The overhead cost applicable to CMH should have been removed from the Medicare cost report. Section 2328 of the PRM states:

> "Nonallowable cost centers to which general service costs apply should be entered on the cost allocation worksheets after all General Service Cost Centers. General service costs would then be distributed to the nonallowable cost centers in the routine stepdown process..."

PWAM Comments

The PWAM stated that it did not have a clear understanding on how the actual dollar amount had been developed, therefore they could not comment on the finding as stated in the draft report. The PWAM stated that although the finding had been discussed during the on site audit work, it still did not have a clear understanding how the amount reported had been developed.

OAS Response

The auditors reviewed direct and indirect costs associated with the CMH. The PWAM had provided maintenance, administrative and accounting services to the subject facility, for which the facility was charged $76,971 for the year representing the actual salary costs. The actual direct costs that were billed to CMH were adjusted from the expenses. We proposed that a non-reimbursable cost center for CMH be established so that direct and indirect or overhead costs could be properly excluded from the cost report per Medicare regulations.

ADMINISTRATIVE & GENERAL ($15,804)

The Administrative and General accounts contained costs which are not allowable under the provisions of the Medicare regulations because they were costs that were not related to patient care. The costs included:

Flowers	$409
Jewelry	529
Tickets to Vegas night	100
Advertising at a football game	160
Flowers & Gifts	640
Unreconciled entry (no support)	9,188
Reconcile entry (no support)	4,778
TOTAL	$15,804

The PWAM purchased flowers, jewelry, gifts and tickets for entertainment, advertising, and gifts totaling $1,838, which according to the PRM are not allowable because these costs are not related to patient care. In addition, PWAM claimed $13,966 for expenses which were not incurred, but merely claimed as an expense for an unreconciled prepaid expense.

Section 2102.3 of the PRM-I states the following with regard to costs not related to patient care:

> "Costs not related to patient care are costs which are not appropriate or necessary and proper in developing and maintaining the operation of patient care facilities and activities. Costs which are not necessary include costs which usually are not common or accepted occurrences in the field of the provider's activity."

PWAM Comments

The PWAM did not provide comments on this finding.

VENDING MACHINE INCOME ($7,000)

A tour of the facility disclosed that the PWAM had vending machines and public pay telephones. They generated $7,000 in revenues during FY 1998. However, the PWAM did not adjust the FY 1998 Medicare cost report to account for the expenses or revenues received. The PWAM officials informed us that the subject income obtained from the vendor equipment was deposited into the Gift Shop account. Since the vendor equipment is not patient related, the cost should not be reimbursable by Medicare. Also, the revenue received from the equipment should be deducted from the FY 1998 Medicare cost report. Section 2106.1 of the PRM states:

> "General--The full costs of items or services...which are furnished solely for the personal comfort of the patients (full costs include costs both directly associated with personal comfort items or services plus an appropriate share of indirect costs) are not includable in allowable costs of providers under the Medicare program."

PWAM Comments

The PWAM did not provide comments on this finding.

BAD DEBTS ($1,995)

Bad debts are amounts considered to be uncollectible from accounts and notes receivable which are created or acquired in providing services (Sec. 302.1 of PRM-I). Medicare reimburses allowable bad debts resulting from uncollectible deductibles and coinsurance due from the Medicare patients and meeting the criteria set forth in Section 308 of PRM-I. Allowable bad debts must relate to specific deductibles and coinsurance amounts pertaining to charges Medicare covered. The PWAM improperly claimed $1,995 as a bad debt of a patient that did not pertain to covered charges and therefore not eligible for reimbursement. Section 308 of the PRM-I states:

"A debt must meet these criteria to be an allowable bad debt: (1) The bad debt must be related to covered services and derived from deductible and coinsurance amounts..."

PWAM Comments

The PWAM did not provide comments on this finding.

BEAUTY SHOP ($13,639)

During a tour of the facility, we noted that the "Beauty Shop" (which is a non-reimbursable cost center) was reflected in the cost report with an incorrect square footage of 399 square feet. The correct footage was 740 square feet. The Beauty Shop is a cost center that is not related to patient care according to Medicare regulations and is setup as a non-reimbursable cost center in the Medicare cost report. The actual effect of this audit adjustment could be determined when the cost report is adjusted with other adjustments. We estimate that utilizing the correct square footage for the Beauty Shop will result in $13,639 of additional overhead costs allocated to this non-reimbursable cost center through the cost report process.

PWAM Comments

The PWAM did not provide comments on this finding.

RECOMMENDATIONS

We recommend that the FI instruct PWAM to strengthen its procedures to ensure that costs in violation of Medicare rules and regulations are excluded from the Medicare cost report prior to submission. We also recommend that the FI adjust the FY 1998 Medicare cost report to reflect the $1,582,079 in unallowable cost disclosed during our audit.

ANNABURG MANOR

PRINCE WILLIAM HEALTH SYSTEM

September 27, 2001

By Federal Express

James J. Maiorano
Department of Health and Human Services
Office of the Inspector General, Office of Audit Services
150 S. Independence Mall West, Suite 316
Philadelphia, Pa. 19106-3499

Re: Draft Report, Office of Audit Services, Department of Health and Human Services' Office of Inspector General ("OAS"); Annaburg Manor Nursing Home Medicare Cost Report For Fiscal Year 1998 (Common Identification No. A-03-00-00215)

Dear Mr. Maiorano:

This letter constitutes Annaburg Manor Nursing Home's ("AMNH's") response to the above-referenced draft report ("Draft Report"). AMNH vigorously contests the three principal findings in the Draft Report which collectively account for $1,543,637 or 98%, of the $1,582,079 in "unallowable" costs purportedly identified by OAS. We address each of these three findings in turn. By this letter, AMNH also requests an exit conference with OAS to discuss the contents of the Draft Report as well as this response.

DRAFT FINDING NUMBER 1: THERAPY COSTS

Background

AMNH contracts with Prince William Hospital ("PWH") to secure physical, occupational, speech, and respiratory therapy for AMNH residents. Given that AMNH and PWH are controlled by a common parent company, Prince William Health System, they constitute "related organizations" for purposes of Medicare reimbursement. Thus, AMNH is entitled to Medicare reimbursement only for the actual costs incurred by PWH in furnishing medically-necessary covered services to AMNH residents (i.e., AMNH may not secure Medicare reimbursement for any profit made by PWH in furnishing therapy to AMNH residents). Consequently, PWH bills AMNH for the foregoing therapy services by (1) calculating the proportion of time that each therapist spends treating residents at AMNH and (2) charging AMNH for that proportion of the therapist's actual salary.

OAS Contention

In the Draft Report, OAS contends that $1,386,131 in therapy services furnished to AMNH residents should be disallowed because "AMNH did not provide auditable documentation to substantiate the number of actual therapy hours billed to AMNH" and, therefore, OAS is "unable to verify the basic supporting data of the therapy costs billed."[1] Thus, the claims are "unallowable due to lack of supporting documentation."

AMNH Response

AMNH has provided OAS with ample documentation to substantiate the number of therapy hours worked and costs incurred by PWH in furnishing therapy services to AMNH residents. Specifically, AMNH has furnished the OAS with four categories of documents which fully support the therapy services provided to AMNH residents. They are as follows:

1. Payroll records from PWH which specifically state the name of each therapist providing services at AMNH, the dates on which the therapist furnished such services, and the amount of time the therapist spent furnishing care to AMNH residents on each such date.

2. Monthly invoices, prepared from each therapist's daily time sheets, provided by PWH to AMNH, detailing the total number of therapy hours, by therapist, provided for the month.

3. A sample PWH payroll report, also generated from the individual therapist's daily time sheets, indicating the name of the therapist and the date and total number of hours worked at AMNH.

4. A sample monthly therapy log containing the names of Medicare patients, the type of therapy provided, the number of therapy units provided and the date on which such services were provided.[2]

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[1] Draft Report at 4.

[2] We would be pleased to provide you with an additional copy of these documents upon request.

Medicare regulations and provisions of the of the Provider Reimbursement Manual ("PRM") set forth the documentation requirements for items claimed on a cost report. In pertinent part, these provisions require that providers maintain "sufficient financial records and statistical data for proper determination of costs payable under the program." 42 C.F.R. § 413.20(a). The regulations go on to provide that:

> Adequate cost information must be obtained from the provider's records to support payments made for services furnished to beneficiaries. The requirement of adequacy of data implies that the data be accurate and in sufficient detail to accomplish the purposes for which it is intended. Adequate data capable of being audited is consistent with good business concepts and effective management . . ."

42 C.F.R. § 413.24(c); see also PRM-I § 1417.

Beyond the requirement that the documentation be "capable of being audited," there is little guidance on what specific documentation providers are to maintain to support specific types of costs. A decision by the Provider Reimbursement Review Board ("PRRB"), however, has held that the very type of documentation of therapy services maintained by AMNH is sufficient to support Medicare payment. Specifically, in Desert Springs Hospital v. Aetna, the fiscal intermediary denied Medicare reimbursement to a skilled nursing facility ("SNF") for therapy services furnished to facility residents under arrangement with a vendor, concluding that the SNF did not adequately document its costs.[3] The PRRB reversed this determination and authorized reimbursement for those periods in which the vendor maintained "daily" time sheets. AMNH has provided just such documentation to OAS. AMNH has provided a daily therapy log indicating the name of each patient receiving therapy and the date on which therapy was provided. In addition, AMNH has provided documentation indicating the daily hours of therapy performed by each therapist at AMNH. Together, these documents clearly meet the standard for "adequate documentation" set forth by the PRRB in Desert Springs Hospital.

In light of the expansive documentation AMNH has already disclosed (and will augment upon request), AMNH is entitled to all Medicare reimbursement received for therapy services in the fiscal year ending June 30, 1998.

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[3] No. 96-D53 (Aug. 21, 1996).

DRAFT FINDING NUMBER 2: PERSONAL LAUNDRY AND OVERHEAD COSTS

Background

OAS alleges that AMNH has improperly claimed $80,535 for personal laundry costs and that this amount should be disallowed. However, this $80,535 actually represents costs associated with both *institutional* and *personal* laundry costs. While AMNH has a contract with PWH for it to launder AMNH's institutional laundry, AMNH personnel must prepare the soiled institutional laundry for transport to PWH and unload the clean laundry upon its return. The same 2,120 square feet of space within AMNH is used to process this institutional laundry (i.e., soiled linen is accumulated in this space, prepared for transport to PWH, received back from PWH, and distributed to AMNH residents from this space) *and* to launder personal clothing items of AMNH residents.

OAS Contentions

The OAS contends that AMNH improperly claimed $80,535 in personal laundry costs and that "personal laundry expenditures must be removed from the applicable Medicare cost report."

AMNH Response

AMNH does not dispute that personal laundry costs of its Medicare residents should not be reimbursed by Medicare. AMNH differs with OAS, however, on how those costs should be removed from the AMNH cost report.

Because the costs and space associated with personal laundry use cannot be adequately separated from the institutional laundry functions described above, the costs associated with the personal laundry are appropriately removed from the cost report via a revenue offset. The instructions to the cost report are clear that when costs associated with an item are not separable, a non-reimburseable cost center cannot be accurately determined. PRM II § 3519 provides that Worksheet A-8 adjustments are to be utilized when "the cost, including direct cost and all applicable overhead, cannot be determined." Indeed, the worksheet instructions specifically list patient personal laundry cost as an item appropriately included on Worksheet A-8. PRRB decisions are in accord. See, e.g., Charter Peachford Hospital v. Mutual of Omaha Ins. Co., PRRB Dec. No. 84-D122, aff'd, HCFA Admr. Dec., July 13, 1984 (when direct or indirect costs for noncovered services cannot be determined, income received for the services should be used to offset costs).

The proper way to handle this item is as a revenue offset equal to monies received for the personal laundry. This amount, $14,294, represents revenue received exclusively from private-pay patients and was obtained from the working trial balance of AMNH.

Conclusion

AMNH requests that the auditor's proposed adjustment be removed and that, in lieu thereof, an adjustment be made to offset the revenue of $14,294 on Worksheet A-8.

DRAFT FINDING NUMBER 3: ADMINISTRATIVE AND MAINTENANCE COSTS

Background

AMNH provides meals, accounting services, administrative services, and maintenance services to Caton Merchant House, a retirement community owned by PWH and located adjacent to AMNH. AMNH does not report or otherwise seek reimbursement for the direct costs associated with providing the foregoing services.

OAS Contentions

OAS contends that AMNH improperly claimed $76,971 in indirect costs associated with the provision of services to Caton Merchant House.

AMNH Response

Despite repeated requests from AMNH representatives, OAS has refused to disclose how it derived the $76,971 in purportedly unallowable indirect costs. By withholding such information, OAS has precluded AMNH from reviewing the basis for these claims and deprived AMNH of a meaningful opportunity to respond.

Conclusion

AMNH requests that the auditor's proposed adjustment be rejected until the basis for such adjustment is disclosed to AMNH and AMNH receives a meaningful opportunity to respond.

* * * * * *

On behalf of AMNH, I request these comments be given thorough consideration before OAS finalizes the Draft Report. My staff and I would be pleased to provide any additional information you might require.

Sincerely,

Carol E. Mullins

Carol Mullins
Administrator

LMB-L

bc: Ardell Butler
Linda Boze-Lockowandt
H. Guy Collier
Glenn Walker