DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General
Office of Audit Services
REGION IV
61 Forsyth St., SW, Room 3T41
ATLANTA, GEORGIA 30303-8909

Memorandum

Date : February 2 1,200 1

From : Regional Inspector General
for Audit Services, Region IV

Subject : Final Report, Review of Costs of Outpatient Clinics
at Coral Gables Hospital (CIN A-04-00-01208)

To : Rose Q-urn-Johnson
Regional Administrator
Health Care Financing Administration

This report provides you with the results of our audit of outpatient clinics operated by Coral Gables Hospital. The audit covered the fiscal years ending (FYE) 1994 through 1998.

The audit objective was to determine whether clinic costs claimed by Coral Gables Hospital, (the Hospital), were allowable for Federal Medicare reimbursement.

Our audit showed that the Hospital incorrectly reported certain data in its costs reports for FYEs 1996 through 1998. These errors occurred in the accounting and recording of financial and statistical data for clinic activities. A preliminary estimate by the Hospital's Fiscal Intermediary (FI) showed the Hospital was overpaid Medicare funds by $384,295. The inappropriate reporting occurred because the Hospital lacked sufficient controls in its accounting system to ensure that fiscal data for the clinic operations contained no material errors. Moreover, Hospital officials believe that changes in the accounting system contributed to the errors we discovered.

We are recommending that the Health Care Finance Administration (HCFA) direct the Hospital's FI to (a) adjust the cost reports to correct the errors for FYEs 1996 through 1998 , (b) recover the Medicare overpayments of $384,295, and (c) instruct the Hospital to ensure that future cost reports are prepared free of the types of errors identified during our audit.

The Hospital's comments to the findings have been incorporated into this report. The complete text of the comments are attached at Appendix E. Our response to the comments is also included in the report.

BACKGROUND

The Medicare program, administered by HCFA, was established by Title XVIII of the Social Security Act. Medicare provides health insurance coverage for people aged 65 and over, the disabled, people with end stage renal disease, and certain others who elect to purchase Medicare coverage. Under section 1833(a), the Act provides for coverage of medical services, including

outpatient clinic services. The HCFA reimburses outpatient services through both the Medicare Part A and Medicare Part B Programs. Medicare Part A reimbursement for outpatient clinic services is based on the cost of services to the Medicare patients.

As a Medicare Part A provider, the Hospital received reimbursement for outpatient services from its FI. At the end of each Medicare accounting period, the Hospital filed a cost report with its FI. By filing the cost report, the Hospital reconciled its costs to the Medicare payments received during the year from the FI. On the cost report, the Hospital divided its costs into three groups: general service, routine, and ancillary services. General Service costs are also known as overhead costs because the costs benefit the Hospital's patient services as a whole. Routine costs are the boarding costs of inpatient services. Ancillary costs are those costs that are identifiable to a particular hospital service. Clinic costs belong to the ancillary group.

To establish a standardized method of reporting, HCFA has assigned line numbers on the cost report for each class of costs. The HCFA has established line 60 on which a hospital is to report clinic costs. In order to be considered allowable for reimbursement, these costs must meet the requirements set forth in the Code of Federal Regulations (CFR) for the Medicare program as well as HCFA's program instructions.

The Hospital, which is an acute care facility, provided outpatient physician clinic services in the greater Miami area from FYE 1994 through 1998. At the time of our review, the Hospital was owned by Tenet Healthcare Corporation (Tenet) of Santa Barbara, California. Tenet acquired the Hospital through a merger with OrNda Healthcorp in February 1997.

OBJECTIVE, SCOPE AND METHODOLOGY

The objective of our audit was to determine whether the clinic costs claimed by the Hospital were allowable for Medicare reimbursement.

We conducted our audit in accordance with generally accepted government auditing standards. The audit was conducted from October 1999 through June 2000. Site work was performed at the Hospital's main location in Coral Gables, Florida.

We limited consideration of the internal control structure to those controls concerning the recognition of revenue and expenses reported on the cost reports because the objective of our review did not require an understanding or assessment of the Hospital's complete internal control structure. However, we did obtain an understanding of the Hospital's internal controls over its preparation of Medicare cost reports and the filing of those reports with the FI. And, we calculated the amount of improperly reported costs claimed as outpatient clinic services. Throughout our audit, we judgmentally sampled and reviewed supporting documentation for clinic and other related costs.

To accomplish our objective, we reviewed:

- Federal regulations related to outpatient clinic services;
- the Hospital's cost reports for FYE 1994 through 1998, and related working papers furnished by the Hospital's FI;
- the Hospital's accounting records for FYEs 1994 through 1998;
- the Provider Statistical and Reimbursement Report for FYEs 1996 through 1998 furnished by the FI; and
- Medicare Part B claims filed by the Hospital, and its contractor, with the Medicare Part B carrier.

FINDINGS AND RECOMMENDATIONS

Our audit of the outpatient physician clinic activities centered on the reimbursements shown on line 60 of the Hospital's Medicare cost reports for FYEs 1994 through 1998.

We determined that costs of outpatient physician clinic costs for FYEs 1994 and 1995 were correctly applied and had no material impact on the Medicare reimbursement. However, we did uncover a number of errors the Hospital made when preparing its cost reports for FYEs 1996 through 1998. Based on estimates provided by the FI, the Hospital was overpaid Medicare funds in the amount of $384,295.

The Hospital reported its general ledger costs by an account or a group of accounts on each applicable cost report line number. By using a specified distribution method, the Hospital allocated the general service cost centers to the ancillary cost centers. The Medicare revenues of each ancillary cost center were divided by its gross revenues to determine the Medicare utilization ratio. The Medicare utilization ratio was then multiplied by the ancillary center's costs to determine the Hospital's Medicare cost reimbursement. In this manner, the Hospital obtained its Medicare reimbursement. However, its methodology contained errors in four areas: groupings and reclassifications, unallowable costs, provider-based physician compensation, and revenues.'

COST GROUPINGS AND RECLASSIFICATIONS

In the three successive FYEs through 1998, the Hospital made errors in either its grouping or reclassifications of certain costs.

'Appendix A shows the amount of errors by FYEs 1996, 1997 and 1998.

Grouped Clinic Costs

The Hospital's cost report account groupings were in error for FYEs 1996 and 1997. In each of these years, the Hospital grouped several types of clinic services on line 60. The HCFA's instructions set forth the rules of reporting numerous outpatient clinics. The instructions require that where more than one clinic exists and each clinic is separately costed, then each clinic should be reported on a separate line of the cost report (Provider Reimbursement Manual (PRM) II 3610). In FYE 1996, the Hospital did not follow HCFA's instructions; but, rather reported the total costs for physician clinics (PCP), senior health clinics, partial hospitalization-psychiatric (PHP) and administrative and general costs together on line 60. In FYE 1997, the Hospital, again, made a similar error and reported the total PCP clinics, senior health centers, and PHP costs on line 60.

Reclassified Rent Expense

We determined that in 1996, 1997 and 1998. the Hospital incorrectly reclassified rent expense from line 60 clinic costs to capital costs. Medicare regulations and HCFA's instructions require the reclassification of lease expense to capital costs (PRM II 3611). The purpose of cost reclassifications is to ensure that costs are properly assigned to a proper activities. However, the Hospital did not report the correct statistics associated with the clinic rentals. Because of this omission, the rent expense was allocated to all areas other than the clinic cost center.

UNALLOWABLE COSTS

Some amounts claimed by the Hospital on line 60 were not reimbursable under the Medicare regulations. In order to be reimbursable under Medicare, the cost must be reasonable and necessary and related to patient care (42 CFR 413.9). The Medicare regulations also require the Hospital to maintain sufficient financial records so a determination can be made as to whether the cost is an allowable Medicare charge (42 CFR 413.20).

Unsupported Costs

In FYE 1996, the Hospital claimed reimbursement for marketing costs. However, the Hospital did not provide adequate documentation to support the marketing costs as reimbursable Medicare costs. In FYE 1996 and 1997, the Hospital also did not adequately support contract labor as reimbursable Medicare costs.

Closed Clinic Costs

In FYEs 1996, 1997 and 1998, the Hospital systematically closed five clinics and, therefore, no longer provided care to Medicare beneficiaries at these locations. However, the Hospital continued to claim reimbursement for rent and other costs after the clinics were closed. Contrary to Medicare regulations, the costs which the Hospital continued to claim after the clinics closed would not be reasonable and necessary and related to patient care.

PROVIDER-BASED PHYSICIAN COMPENSATION

The Hospital did not comply with the Medicare regulations regarding Provider-Based Physician (PBP) compensation reported on line 60 of the cost report. The Medicare regulations and HCFA's program instructions address the proper methods for reporting and allocating of PBP costs.

Reporting PBP Costs

The Medicare regulations (42 CFR 4 15) and HCFA guidance (PRM II 36 15) provide instructions for properly reporting PBP compensation. These instructions require hospitals to list total physician compensation paid, total professional charges, and the provider's administrative component as hours and percentages. Hospitals are also required to list this information on HCFA's Form 339.

The Hospital did not comply with either Medicare regulations or the HCFA instructions for reporting and the claiming of reimbursement for PBP compensation. In FYE 1996, the Hospital only reported fifty-one percent of the PBP compensation. The balance of the compensation was not disclosed in the cost report as required by HCFA instructions. The balance was also omitted from HCFA's Form 339. In FYEs 1997 and 1998, the Hospital reported none of the PBP compensation on either its cost reports or the HCFA Form 339.

Allocating PBP Costs

To properly support cost allocations of a physician's compensation, the Hospital is required to have a written allocation agreement with the physician (42 CFR 415.60). The Hospital was unable to provide us the support for the cost allocations of physicians' compensation costs. However, the Hospital continued to claim the costs for Medicare reimbursement.

REVENUES

The Hospital reported incorrect revenues on line 60 of the cost report for FYEs 1996 through 1998. According to HCFA instructions, groupings of dissimilar activities are to be shown on separate lines of the cost report (PRM II 3610). The Hospital combined outpatient psychiatric revenues with outpatient physician clinic revenues. The Hospital maintained separate accounting records for each type of these dissimilar types of outpatient services.

The Hospital's outpatient clinic revenues also contained revenues that were generated by other ancillary services. The HCFA's instructions require the Hospital to reclassify all ancillary services billed by the clinic to the ancillary that provided the service (PRM II 3620). In this instance, the Hospital also did not follow HCFA's cost report instructions. By not applying HCFA's instructions, the Hospital caused an understatement of gross revenues and an overstatement of Medicare utilization in the affected ancillaries to be shown on its cost reports.

MEDICARE OVERPAYMENTS

At our request, the Hospital's FI processed the cost report adjustments shown in Appendices B, C, and D. Based on the FI's computations, the Hospital was overpaid $384,295 for the 3-year period ended December 31, 1998.

ACCOUNTING PROCEDURES AND CONTROLS

In preparing its cost reports, a hospital should follow procedures that contain sufficient controls to ensure that claims for Medicare reimbursement comply with program regulations and HCFA instructions. Such procedures and controls would also help ensure that when the cost report was submitted to the FI, few or no corrections would be deemed necessary after the FI completed its review.

We found that some of these controls were lacking at the Hospital, thereby contributing to the errors we uncovered. During our review, we noted that some elements in the accounting system were less than effective in grouping and collecting the costs applicable to clinic operations for FYEs 1996 through 1998. When the cost report was prepared, the Hospital incorrectly combined accounts of dissimilar services; thus, inappropriately increasing the Medicare reimbursement.

Hospital and Tenet officials noted that the changes in the accounting system as well as the changes in ownership most probably contributed to the numerous errors we discovered. The officials believed that the most recent version of the general ledger accounts was of sufficient detail to preclude future errors of the kind we found. The officials also indicated that future filings of cost reports would be done by paying sufficient attention to reporting details to ensure that the costs would be claimed according to program regulations and HCFA instructions.

CONCLUSIONS AND RECOMMENDATIONS

By not following existing Medicare regulations in preparing its cost reports, the Hospital erred significantly in exhibiting its line 60 outpatient clinic costs. As a result, the Hospital's Medicare reimbursement will need to be adjusted.

We recommend that the HCFA direct the Hospital's FI to:

(a) adjust the cost reports to correct the errors for FYEs 1996 through 1998;
(b) recover the Hospital's overpaid Medicare reimbursement totaling $384,295; and
(c) instruct the Hospital to ensure that future cost reports are prepared free of the types of errors identified during our audit.

Appendixes B, C and D present the details pertaining to our recommended adjustments. To aid the HCFA and FI officials in making the corrections, the Appendices show how the adjustments occur in the cost report format.

HOSPITAL COMMENTS

In it's written response to the draft report, the Hospital noted that the inadvertent cost reporting errors were due to circumstances which had been changed. The Hospital stated that its current accounting system and cost report preparation procedures provide additional safeguards against such errors.

The Hospital raised concerns regarding the manner in which we exhibited the total amount of errors. The Hospital believed discussing the total of the errors would not permit the readers to have a clear understanding of the actual effect of these errors on the Medicare reimbursement. The Hospital also pointed out that seventy-five percent of the cost reporting errors were reclassifications of costs or revenues from one reimbursable cost center to another.

The Hospital's response also contained specific comments on some of our proposed adjustments. In these comments, the Hospital suggested certain corrections to those adjustments.

OIG RESPONSE

Some improvements occurred, apparently because of the current accounting system. Most notably, the amount of errors we found decreased from 1996 to 1998 with the most significant decrease in cost groupings and reclassifications of accounting information.

We agree, in part, with the Hospital's comments that exhibiting the total accounting errors might lead readers to inappropriate conclusions regarding the effect of these errors on the Hospital's Medicare reimbursement. However, it is also appropriate to recognize the amounts of adjustments that are needed to correct the errors on the cost reports. We have shown the total adjustments by category, by fiscal year, in Appendix A. Specific details on each of the adjustments we are recommending do, however, appear in Appendixes B, C and D in the cost reporting format to facilitate the reviews by others and to assist appropriate, corrective actions by cognizant HCFA and FI officials. We have removed other references to the total amount of the errors in the narrative sections of this report.

We also evaluated the Hospital's comments on several of the proposed adjustments. We consider some of the comments valid, and we have modified the Appendices B, C and D. Because the nature of the comments was mainly directed at the reporting of statistical information, there would be little effect on the Medicare overpayments made to the Hospital.

The complete text of the Hospital's comments is presented in Appendix E. Our response to specific comments is shown in Appendix F.

* * * * *

We would appreciate your views and information on the status of action taken or contemplated on our recommendations within the next 60 days. If you have any questions, please call me or Donald Czyzewski, Audit Manager, at (305) 536-5309, extension 10.

To facilitate identification, please refer to the Common Identification Number (CIN) A-04-00-01208 on any correspondence related to this report.

Charles J. Curtis

Attachments

APPENDICES

Appendix A

CORAL GABLES HOSPITAL

Summary of Recommended Cost Report Changes

	FYE 1996	FYE 1997	FYE 1998	Totals
Reclassifications	$3,162,466	$1,844,600	$93,227	$5,100,293
Unallowable Costs	80,602	232,553	368,189	681,344
Provider-Based Physicians Compensation	506,217	481,845	146,835	1,134,897
Revenues	368,887	279,795	25,933	674,615
Total Errors	$4,118,172	$2,838,793	$634, I84	$7,591,149

Description	New Line No.	Column	As Filed	Adjustment	As Adjusted	Regulations
W/S A-6 Reclassifications						
Administrative & General	6 00		$ 0	$ 698,201	$ 698,201	PRM ll 3610
Outpatient Clinics	60.01		0	1,549,687	1,549,687	
MedWise Clinics	60.02		0	1,649,377	1,649,377	
Chic	60.00		0	(3,897,265)	(3,897,265)	
To reclassify the costs of the outpatient clinics that were grouped on line 60 to separate cost report lines. The Hospital incorrectly grouped dissimilar types of outpatient services on line 60 in FYE 12/31/96.						
PHP	60.00		$ 0	$ 421,027	$ 421,027	PRM II 3610
Old Capital B&F	1.00		0	(407,985)	(407,985)	
Old Capital MME	2.00		0	(13,042)	(13,042)	
To reserve the Hospital's as filed reclassification of capital costs. No statistics were set up to allocate the capital costs. Direct assignment of the rent expense is allowable, as the usage of the B-l data may cause cost finding distortion.						
WIS A-8 Adjustments						
Outpatient Clinics	60.01		$ 0	$ (80,602)	$ (80,602)	42 CFR 413.24
To offset cost the Hospital did not adequately support.						
W/S A-8-2 Adjustments						
PHP	60.00	3	$ 543,200	$ (543,200)	$ 0	42 CFR 415.55
Outpatient Clinics	60.01		0	883,300	883,300	42 CFR 415.60
MedWise Clinics	60.02		0	166,117	166,117	42 CFR 413.24
To report FYE 12/31/96 gross provider based physician compensation. The Hospital had not reported the compensation.						
PHP	60.00	4	$ 543,200	$ (543,200)	$ 0	42 CFR 415.55
Outpatient Clinics	60.01		0	883,300	883,300	42 CFR 415.60
MedWise Clinics	60.02		0	83,058	83,058	42 CFR 413.24
To report professional compensation of the provider based physicians for FYE 12/31/96. The Hospital did not report the compensation.						
MedWise Clinics	60.02	5	$ 0	$ 83,059	$ 83,059	42 CFR 415.55
To report the provider component provider based physician compensation for FYE 12/31/96.						42 CFR 415.60
						42 CFR 413.24
MedWise Clinics	60.02	6	$ 0	$ 76,800	$ 76,800	FR 45207
To report the RCEs for physician compensation. The hospital did not report the RCE rate.						
MedWise Clinics	60.02	7	0	1,019	1,019	42 CFR 415.60
To report provider component hours. The Hospital did not report the provider component hours.						
W/S B Part lll Adjustments						
Outpatient Clinics	60.01	0	$ 0	$ 141,070	$ 141,070	PRMll 3618
Medwise Clinics	60.02	0	0	273,575	273,575	
To record directly assigned clinic rents. The Hospital reclassified the capital costs without the statistics.						

Description	New Line No.	Column	As Filed	Adjustment	As Adjusted	Regulations
W/S B-I Adjustments						
Administrative & General	6.00	5	$ 3,075,396	$ 115,458	$ 3,190,854	42 CFR 413.24
PHP	60.00	5	935,687	(902,658)	33,029	
OP Clinics	60.01	5	0	391,232	391,232	
MedWise Clinics	60 02	5	0	395,968	395,968	
Total Others			15,949,473	0	15,949,473	
Totals			$ 19,960,556	$ 0	$ 19,960,556	
To reclassify B-I Statistics for Employee Benefits - Salaries. The Hospital statistics were incorrectly reported on line 60.						
PHP	60.00	12	136	(114)	22	42 CFR 413.24
OP Clinics	60.01	12	0	94	94	
MedWise Clinics	60.02	12	0	20	20	
Total Others			3,543	0	3,543	
Totals			3,679	0	3,679	
To reclassify B-I Statistics for Cafeteria - FTEs.						
PHP	60.00	15	$ 62,952	$ (62,952)	$ 0	42 CFR 413.24
OP Clinics	60.01	15	0	4,587	4,587	
MedWise Clinics	60.02	15	0	32,896	32,896	
Total Others			3,240,322	0	3,240,322	
Totals			$ 3,303,274	$ (25,469)	$ 3,277,805	
To correct B-I Statistics for Central Supply - Costed Requistions. The Hospital did not support the statistics used in the as filed cost report of 12/31/96.						
OR	37.00	17	$ 20,225,190	$ 24	$ 20,225,214	42 CFR 413.24
X-Ray	41.00		4,336,118	15,457	4,351,575	
Ultrasound	41.01		596,242	181	596,423	
Nuclear Med	41.02		1,288,397	1,450	1,289,847	
Cats Scan	41.03		4,452,557	2,077	4,454,634	
Lab	44.00		14,307,628	51,307	14,358,935	
RT	49 00		6,090,143	602	6,090,745	
PT	50.00		2,527,096	1,562	2,528,658	
EKG/ECG	53.00		2,030,711	16,777	2,047,488	
MSCP	55.00		6,614,557	1,618	6,616,175	
DCP	56.00		18,340,698	5,061	18,345,759	
Diag Mamm	59.02		776,976	150	777,126	
PHP	60.00		662,488	(568,428)	94,060	
OP Clinics	60.01		0	232,964	232,964	
MedWise Clinics	60.02		0	39,657	39,657	
Total Others			39,301,685	0	39,301,685	
Totals			$ 121,550,486	$ (199,541)	$ 121,350,945	
To correct B-I Statistics for Medical Records - Revenues. The Hospital did not support the statistics used in the as filed cost report of 12131196.						
W/S C Corrections						
Outpatient Clinics	60.01	6 & 8	$ 0	$ 357,116	$ 357,116	PRM II 3610
MedWise Clinics	60.02		0	211,312	211,312	
PHP	60.00		662,488	(568,428)	94,060	
Total Others			120,773,352	0	120,773,352	
Totals			$ 121,435,840	0	$ 121,435,840	
To reclassify the Hospital's revenues to its matching cost center line. Revenues for five outpatient clinics were combined into one cost center line in the as filed cost report.						

Description	New Line No.	Column	As Filed	Adjustment	As Adjusted	Regulations
Outpatient Clinics	60.01	6 & 8	$ 357,116	$ (124,152)	$ 232,964	PRM II 3610
MedWise Clinics	60.02		211,312	(171,655)	39,657	
Total Others			120,867,412	0	120,867,412	
Totals			$ 121,435,840	(295,807)	$ 121,140,033	

To adjust gross amounts reported by the Hospital to the audited amounts, excluding professional fees.

OR	37.00	6 & 8	$ 20,255,190	$ 24	$ 20'255,214	PRM II 3610
X-Ray	41.00		4,336,118	15,457	4,351,575	
Ultrasound	41.01		596,242	181	596,423	
Nuclear Med	41.02		1,288,397	1,450	1,289,847	
Cats Scan	41.03		4,452,557	2,077	4,454,634	
Lab	44.00		14,307,628	51,307	14,358,935	
RT	49 00		6,090,143	602	6,090,745	
PT	50.00		2,527,096	1,562	2,528,658	
EKG/ECG	53.00		2,030,711	16,777	2,047,488	
MSCP	55.00		6,614,557	1,618	6,616,175	
DCP	56.00		18340,698	5,061	18,345,759	
Diag Mamm	59.02		776,976	150	777,126	
Total Others			39,523,720	0	39,523,720	
Totals			$ 121,140,033	$ 96,266	$ 121,236,299	

To reclassify ancillary revenues to their proper cost centers. The Hospital incorrectly reported the ancillary revenues as clinic revenues.

W/S D Part V						
Outpatient Clinics	60.01		$ 0	$ 49,930	$ 49,930	PRM II 3610
MedWise Clinics	60.02		0	33,220	33,220	
PHP	60.00		96432	(83,150)	13,282	
Total Others			7764972	0	7,764,972	
Totals			$ 7861404	$ 0	$ 7,861,404	

To adjust the clinic charges reported to the audited Medicare Clinic charges (Revenue Code 510).

Memo - The gross charges reported on W/S C line 60 after the corrections was less than the Medicare Charges reported on line 60 of W/S D Part V. We have reduced line 60 XVIII charges for the amounts reclassified to the separate clinic lines.

Description	New Line No.	Column	As Filed	Adjustment	As Adjusted	Regulations
W/S A-6 Reclassifications						
Outpatient Clinics	60.01	$	0	$ 669,224	$ 669,224	PRM II 3610
MedWise Clinics	60.02		0	1,076,078	1,076,078	
PHP	60.00		0	(1,745,302)	(1,745,302)	
To reclassify the costs of the outpatient clinics that were **grouped** online 60 to separate cost report lines. The hospital incorrectly grouped dissimilar types of outpatient services On line 60 in FYE 12/31/97.						
PHP	60.00	$	0	$ 99,298	$ 99,298	PRM II 3610
Old Capital MME	2.00		0	(99,298)	(99,298)	
To reverse the Hospital's filed reclassification of capital costs. No statistics were set up to allocate the capital costs. We will allow direct assignment of the rent expense, as the usage of B-1 allocations may cause cost finding distortation.						
New Capital MME	4.00	$	0	$ 227	$ 227	PRM II 3610
PHP	60.00		0	(227)	(227)	
To reclassify the capital costs associated with the PHP clinic. The Hospital's as filed reclassifiaction included disimilar types of outpatient services on line 60 in FYE 12/31/97.						
PHP	60.00	$	0	$ 3,648	$ 3,648	PRM II 3610
MSCP	55.00		0	(3,648)	(3,648)	
To reserve the filed A-6 for char-gable supplies. Our findings determined the reclassification **was** incorrect.						
MSCP	55.00	$	0	$ 3,648	$ 3,648	PRM II 3610
PHP	60.00		0	(26)	(26)	
OP Clinics	60.01		0	(2,700)	(2,700)	
MedWise Clinics	60.02		0	(922)	(922)	
To reclassify chargable supplies based on splitting the disimilar services reported on line 60 of the as filed 12/31/97 cost report.						
W/S A-8 Adjustments						
Outpatient Clinics	60.01	$	0	$ (10,557)	$ (10,557)	42 CFR 413.24
To offset cost the Hospital did not adequately support.						
Outpatient Clinics	60.01	$	0	$ (51,576)	$ (51,576)	42 CFR 413.9
MedWise Clinics	60.02		0	(170,420)	(170,420)	
To offset the cost associated to the clinics that were closed. The Hospital, on its 12/31/97 cost report claimed reimbursement for the cost incurred after the clinics were closed.						
WIS A-8-2 Adjustments						
Outpatient Clinics	60.01	3 $	0	$ **346,959**	$ **346,959**	42 CFR 415.55
MedWise Clinics	60.02		0	134,886	134,886	42 CFR 415.60
To report FYE 12/31/97 gross provider based physician compensation. The Hospital had not reported the compensation.						
Outpatient Clinics	60.01	4 $	0	$ 346,959	$ 346,959	42 CFR 415.55
MedWise Clinics	60.02		0	83,656	83,656	42 CFR 415.60
To report the professional compensation of provider based physicians for FYE 12/31/97. The Hospital failed to report the compensation.						
MedWise Clinics	60.02	5 $	0	$ 51,230	$ 51,230	42 CFR 415.55 42 CFR 415.60
To report the provider component provider based physician compensation for FYE 12/31/97.						
MedWise Clinics	60.02	6 $	0	$ 120,000	$ 120,000	FR 45207 PRM I 2182
To set up RCEs for physician compensation. The Hospital did not report the RCE rate.						

Description	New Line No.	Column	As Filed	Adjustment	As Adjusted	Regulations
MedWise Clinics	60 02	7	0	790	790	42 CFR 415.55 42 CFR 415.60

To report provider component hours. The Hospital did not report the provider component hours.

W/S B Part III Adjustments

PHP	60.00	0	$ 493,943	$ (493,943)	$ 0	PRM II 3618
OP Clinics	60.01		0	78,575	78,615	
MedWise Clinics	60.02		0	343,485	343,485	

To adjust the directly assigned capital costs (rents) reported in the as filed 12/31/97 cost report. The Hospital reported directly assigned capital related to disimilar types of service on line 60 and claimed rents after the clinics were closed.

WIS B-1 Adjustments

PHP	60.00	5	$ 368.147	$ (123,963)	$ 244,184	42 CFR 413.24
OP Clinics	60.01	5	0	122,561	122,561	
Total Others			15.676940	0	15,676,940	
Totals		8	16,045,087	$ (1,402)	$ 16,043,685	

To reclassify B-I Statistics for Employee Benefits - Salaries. The Hospital statistics were incorrectly reported on line 60.

PHP	60.00	I5	$ 62,952	$ (62,788)	$ 164	42 CFR 413.24
OP Clinics	60.01	15	0	447	447	
MedWise Clinics	60.02	I5	0	1,802	1,802	
Total Others			6.085.817	0	6,085,817	
Totals			$ 6,148,769	$ (60,539)	$ 6,088,230	

To correct B-I Statistics for Central Supply - Costed Requistions. The Hospital did not support the statistics used in the as filed cost report of 12/31/97.

X-Ray	41.00	17	$ 4,155,906	$ 5,419	$ 4,161,325	42 CFR 413.24
Ultrasound	41.01		4,322,741	226	4,322,967	
Nuclear Med	41.02		767,857	649	768,506	
Lab	44.00		13,940,392	54,562	13,994,954	
RT	49.00		4,832,187	766	4,832,953	
EKG/ECG	53.00		2,909,663	9,158	2,918,821	
MSCP	55.00		6,140,851	1,362	6,142,213	
DCP	56.00		18,659,968	2,991	18,662,959	
PHP	60.00		2,013,239	(299,084)	1,714,155	
OP Clinics	60.01		0	161,715	161,715	
MedWise Clinics	60.02		0	42,947	42,947	
Total Others			57.707.250	0	57,707,250	
Totals			$ 115,450,054	$ (19,289)	$ 115,430,765	

To correct B-I Statistics for Medical Records - Revenues. The Hopspital did not support the statistics used in the as filed cost report of 12/31/97.

W/S C Revenues

Outpatient Clinics	60.01	8	$ 0	$ 184,015	$ 184,015	PRM II 3610
MedWise Clinics	60.02		0	115,069	115,069	
PHP	60.00		2,013,239	(299,084)	1,714,155	
Total Others			115.595.470	0	115,595,470	
Totals			$ 117.608,709	$ 0	$ 117,608,709	

To reclassify the Hospital's revenues to its matching cost center line. Revenues of four outpatient clinics were combined into one cost center line in the as filed cost report.

Description	New Line No.	Column	As Filed	Adjustment	As Adjusted	Regulations
Outpatient Clinics	60.01	8	$ 184,015	$ (22,300)	$ 161,715	PM A-96-7
MedWise Clinics	60.02		115,069	(72,122)	42,947	PRM II 3610
Total Others			117,309,625	0	117,309,625	
Totals			$ 117,608,709	$ (94,422)	$ 117,514,287	

To remove the physician professional fees from gross revenues. The hospital incorrectly reported physician professional fees on Worksheet C of the cost report.

X-Ray	41.00	8	$ 4,155,906	$ 5,419	$ 4,161,325	PRM II 3610
Ultrasound	41.01		4,322,741	226	4,322,967	
Nuclear Med	41.02		767,857	649	768,506	
Lab	44.00		13,940,392	54,562	13,994,954	
RT	49.00		4,832,187	766	4,832,953	
EKG/ECG	53.00		2,909,663	9,158	2,918,821	
MSCP	55.00		6,140,851	1,362	6,142,213	
DCP	56.00		18,659,968	2,991	18,662,959	
Total Others			61,784,722	0	61,784,722	
Totals			$ 117,514,287	$ 75,133	$ 117,589,420	

To reclassify ancillary revenues to their proper cost centers. The hospital incorrectly reported the ancillary revenues as clinic revenues.

W/S **D Part V**						
PHP	60.00	5	$ 1,647,250	$ (67,830)	$ 1,579,420	PRM II 3610
Outpatient Clinics	60.01		0	35,060	35,060	
MedWise Clinics	60.02		0	32,770	32,770	
Total Others			6,794,945	0	6,794,945	
Totals			$ 8,442,195	$ 0	$ 8,442,195	

To adjust the clinic charges reported to the audited Medicare Clinic charges (Revenue Code 510).

Memo: The amount reported as PHP (Line 60) has been adjusted to reclassify only the supported Clinic charges. The Intermediary should update the allowable XVIII charges related to Line 60.

Description	line No.	Column	As Filed	Adjustment	As Adjusted	Regulations
W/S A-6 Reclassifications						
Clinics	60.00		$ 0	$ 93,227	$ 93,227	PRM II 3610
Old Capital	2.00		0	(93,227)	(93,227)	
To reverse the Hospital's reclassifiaction of rents. The Hospital had not reported building square feet for allocation purposes.						
WIS A-8 Adjustments						
Clinics	60.00		$ 0	$ (368,189)	$ (368,189)	42 CFR 413.9
To offset cost associated to closed clinics that were claimed for Medicare reimbursement.						
W/S A-8-2 Adjustments						
Clinics	60.00	3	$ 0	$ 146,835	$ 146,835	42 CFR 413.20
To report the total clinic physician compensation which had not been disclosed in the cost report or the HCFA Form 339.						
Clinics	60.00	4	$ 0	$ 42,370	$ 42,370	42 CFR 413.20
To report the professional component physician compensation that had not been disclosed in the cost report of on the HCFA Form 339.						
Clinics	60.00	5	$ 0	$ 104,465	$ 104,465	42 CFR 413.20 42 CFR 415.55 42 CFR 415.60
To report the provider component physician compensation that was not disclosed in either the cost report or on the HFCA Form 339.						
Clinics	60.00	6	$ 0	$ 120,000	$ 120,000	42 CFR 415.55 42 CFR 415.60 FR (5/5/97 p 45207)
To report the RCE limits in effect during the FYE 12/31/98 cost report.						
Clinics	60.00	7	0	978	978	42 CFR 415.55 42 CFR 415.60
To report the clinics' provider based physician component hours that were supported during the FYE 12/31/98 audit..						
W/S B Part III						
Clinics	60.00	0	$ 475,383	$ (243,869)	$ 231,514	PRMII 3618
To adjust the directly assigned capital costs (rents) reported in the as filed 12/31/97 cost report. The Hospital reported directly assigned capital related to disimilar types of service on line 60 and claimed rents after the clinics were closed.						
W/S B-I Statistics						
X-Ray	41 .00	17	$ 1,682,192	$ 226	$ 1,682,418	
Laboratory	44.00		3,521.051	3,928	3,524,979	
Respiratory	49.00		106,856	60	106,916	
Drugs Charged Patients	56.00		2,816.213	145	2,816,358	
EKG	53.00		574.369	634	575,063	
OP Clinic & Medwise	60.00		69,977	(30,926)	39,051	42 CFR 413.24
Total Others			112.735.853	0	112,735,853	
Totals			$ 121,506.511	$ (25,933)	$ 121,480.578	
To correct the Medical Records statistics to agree to the audited revenue amounts.						

Coral Gables Hospital
A-04-00-01 208
1998

Description	Line No.	Column	As Filed	Adjustment	As Adjusted	Regulations
W/S C Revenues						
Clinics	60.00	7	$ 69,754	$ (30,926)	$ 38,828	PRM II 3610
Total Others			35,626,086	0	35,626,086	PRM II 3620
Totals			$ 35,695,840	$ (30,926)	$ 35,664,914	

To adjust the gross **revenues** as reported to the audited amounts for FYE 12/31/98

Clinics	60.00	8	$ 69,977	$ (30,926)	$ 39,051	PRM II 3610
Total Others			121,436,554	0	121,436,554	PRM II 3620
Totals			$ 121,506,531	$ (30,926)	$ 121,475,605	

To adjust the gross revenues reported to the audited amounts for FYE 12/31/98.

X-Ray	41 .oo	7	$ 1,682,192	$ 226	$ 1,682,418	PRM II 3610
Laboratory	44.00		3,521,051	3,928	3,524,979	PRM II 3620
Respiratory	49.00		106,856	60	106,916	
Drugs Charged Patients	56.00		2,816,213	145	2,816,358	
EKG	53.00		574,369	634	575,003	
Total Others			26995,159	0	26,995,159	
Totals			$ 35,695,840	$ 4,993	$ 35,700,833	

To reclassify the ancillary revenues reported as clinic revenues on line 60. The Hospital incorrectly reported the other ancillary billings as clinic revenues.

W/S D Part V						
Clinic	60.00	5	$ 53,825	(46,260)	$ 7,565	PRM II 3610
Total Others			8,685,104	0	8,685,104	PRM II 3620
Totals			$ 8,738,929	(46,260)	$ 8,692,669	

To adjust the clinic charges reported to the audited Medicare clinic charges (Revenue Code 510) for FYE 12/31/98.

CORAL GABLES
Hospital
Tenet South Florida HealthSystem

3100 Douglas Road
Coral Gables, FL 33134
Tel 305 445 8461
Fax 305 441 6879

December 19, 2000

Charles J. Curtis
Regional Inspector General
Office of Audit Services, Region IV
61 Forsyth St., SW, Room 3T41
Atlanta, Georgia 30303-8909

Re: *Review of Costs of Outpatient Clinics at Coral Gables Hospital*
CIN A-04-00-01 28

Dear Mr. Curtis:

We received your letter dated August 8, 2000 and the draft audit report entitled *Review of Costs of Outpatient Clinics at Coral Gables Hospital* ("Report"). According to your letter, the Report is not to be considered final as it is subject to further review and revision.

As we stated in our letter of September 1, 2000, the inadvertent cost reporting errors identified in the Report ("Cost Reporting Errors") were due to circumstances which have since changed. For example, the Report correctly states that the principal reasons for the cost center grouping inconsistency were related to a lack of sufficient detail in the prior accounting systems. and a change of ownership of the hospital. The current accounting systems and cost report preparation procedures provide additional safeguards against such errors. In addition, please note that on page two, paragraph three of the Report, the merger date is February 1997 instead of October 1996.

We strongly object to the dollar amount ascribed to the Cost Report Errors throughout the Report as grossly misleading for three reasons. First, the impact to the Medicare program is substantially less than $7.6 million. Second, fully seventy-five percent of the $7.6 million are reclassifications of cost or revenues from one reimbursable cost center to another. Third, the $7.6 million is the sum of recommended adjustments to cost reclassifications, provider-based physician compensation and revenue. This mischaracterization of the dollar amount of the Cost Report Errors conceals important facts, and has the potential for unnecessarily alarming the reader. in particular a reader that does not have a clear understanding of the Medicare cost report. The only meaningful number to any reader of the Report is the estimated impact to the Medicare program.

On December 13, 1999 the Office of Audit Services advised us that although this review was authorized by the Social Security Act, a final determination of the propriety and accuracy of

the recommended adjustments would be made by the fiscal intermediary. Based on our thorough review of your workpapers, we have identified several procedural and technical errors in the recommended cost report adjustments included in the Report. The rationale for our position and proposed corrections to the recommended cost report adjustments is attached (see Attachment 1) and is part of this letter. We believe that these straightforward issues should be resolved by your office prior to issuing the final report. Regardless of the process followed by the Office of Audit Services with respect to the Report, we reserve all rights to a fair hearing and judicial review under applicable laws and regulations.

If you have any questions regarding the above, please contact me at *(305)* 441-6801.

Sincerely,

Martha Garcia

Martha Garcia, RN, MBA/MSN
Chief Executive Officer

Attachment

FYE 12/31/96

1. A reclassification was proposed to move capital costs of the Outpatient Clinic and Medwise Clinics back to its respective cost centers through two separate adjustments. As there were no square footage statistics assigned on w/s B-l columns 1-4 for these two cost centers, the capital-related cost (lease expense) should have been directly assigned. We believe that this necessitates an additional adjustment on w/s B Pt III col 0 of $14 1,070 (total lease expense on wp J-l /6 of 14 less nonallowable closure expense of $6,382 per wp J-1/13 of 14) on Ln 60.01 and $273,575 on Ln 60.02 (per wp J-1/6 of 14).

2. An adjustment was proposed to correct the Central Supply costed requisition statistics on w/s B-1. We disagree with the amount of the reclassification as this only reflects the nonchargeable amounts (530.02) whereas the rest of the cost centers include both chargeable (530.01) and nonchargeable (530.02) expenses. To avoid distorting the % to total computation, the reclassification amount should be $22,428 to Ln 60.01 and $38,488 to Ln 60.02 on w/s B-l col 15.

3. An adjustment was proposed to reclassify ancillary revenues to their proper cost centers on w/s C columns 6 and 8. There should be a corresponding adjustment on the gross revenue statistics on w/s B-l col 17 to reflect the adjustment on w/s C for proper matching. The as adjusted amount on w/s B-l col 17 should reconcile back to the as adjusted amount on w/s C col 8.

4. Although an adjustment was proposed on workpaper J- 1/7 of 14 to remove unsupported revenue as well as revenue being reclassified to the ancillary cost centers, this adjustment was not reflected on w/s C. We believe that there should be an additional adjustment on w/s C for the following amounts: ($124,152) to Ln 60.0 1 and ($17 1,656) to Ln 60.02. With the additional adjustment, w/s B-l co1 17 and w/s C Lns 60.01 and 60.02 would reconcile.

FYE 12/31/97

1. A reclassification was proposed to move capital costs of the Outpatient Clinic and Medwise Clinics back to its respective cost centers through two separate adjustments. As there were no square footage statistics assigned on w/s B-1 columns l-4 for these two cost centers, the capital-related cost (lease expense) should have been directly assigned. We believe that this necessitates an additional adjustment on w/s B Pt III col 0 of $78,575 on Ln 60.01 (total lease of $124,028 per wp O-1/5 of 21 less disallowances for closed clinics per wps O-1/13 of 21, O-1/15 of 21 and O-1/16 of 2 1) and $343,485 on Ln 60.02 (total lease of $468,984 per O-1/5 of 21 less disallowance of $125,499 per wp O-1/1 7 of 21). Additionally, the as-filed amount of

$493.943 on w/s B Pt III col 0 Ln 60 needs to be eliminated as capital costs have been reclassed to the appropriate cost centers.

2. Several adjustments were proposed to correct the physician fees on w/s A-8-2. We have been unable to trace the amounts on the draft adjustment report to the workpaper. Workpaper N-l 1/3a of 14 indicates the following amounts while numbers in italics reflect the draft adjustment report amounts:

W/s A-8-2	Col 3 (per wp)	*Col 3 (per draft)*	Col 4 (per wp)	*Col 4 (per draft)*	Col 5 (per wp)	*Col 5 (per draft)*
Ln 60.01	346,959	329,751	346,959	329,751	0	0
Ln 60.02	134,887	*212,829*	83,656	80,875	51,231	*ERR*

As reflected above, if the report is being finalized using the draft amounts, there would be a fatal error as the sum of columns 4 and 5 do not equal col 3 for Ln 60.02. If changes have been subsequently made, please provide the revised workpapers.

3. Similar to FYE 1996, an adjustment was proposed to increase ancillary revenues per the auditor's findings on w/s C. We believe that there should be a corresponding adjustment to w/s B-l col 17 (gross revenue statistics) for proper matching.

4. An adjustment was proposed to reclassify the gross salary statistics to be consistent with the expense reclassification on w/s A. Although theoretically this is proper, the amount of the adjustment should really be a reclassification of ($122,661) out of Ln 60 and a +$122,661 to Ln 60.01. These amounts can be traced to the trial balance and the expense grouping schedule.

5. An adjustment was proposed to correct the Central Supply requisition statistics by using the non chargeable supply expense of the current year. We disagree with this adjustment. As-filed *statistics* used *prior year amounts* which include both chargeable and non chargeable supplies. The proposed adjustment for the three cost centers used *current year's* non chargeable supply amount only. In order to preserve the correct % to total allocation, similar statistics should be used for all cost centers, i.e.. use prior year statistics to maintain similar statistics for all cost centers.

FYE **12/31/98**

1. An adjustment to w/s B-l col 5 was proposed to reconcile gross salary amount to the trial balance. We believe this adjustment needs to be deleted as the as-filed amount *does* trace to the trial balance. The gross salary statistics include other items

considered salary such as bonus, severance, vacation, holiday and sick, and paid time off. This is applied consistently among all the various cost centers.

2. An adjustment to correct the gross revenue statistics for Ln 60 was proposed. We believe that the adjustment amount needs to be increased to ($30,925) to incorporate the $4,993 identified and reclassified out as ancillary revenue on a separate adjustment per wp T-1/8 of 12 and T-119 of 12.

3. Although an adjustment was proposed to reclassify clinic revenue to the various ancillary cost centers on w/s C, this was not reflected on w/s B-l col 17 gross salary statistics. Consequently, we believe an additional adjustment needs to be made on w/s B-l col 17 for the various ancillary cost centers for proper matching.

4. An adjustment was proposed to remove expenses related to the closure of the clinics. This includes lease expenses of closed clinics. As these expenses have been eliminated, there needs to be a corresponding adjustment on w/s B Pt III col 0 Ln 60 for ($249,375). This amount was derived by adding all the lease expense of building and equipment to equal $568,610 then reduced by the disallowed lease expense per workpapers T-1/7-12, T-l/l 1-12, S-12/2 of 36 and S-3/6b of 6.

******

Coral Gables Hospital
A-04-00-0 1208

OAS Response to Hospital Comments[2]

The following responses correspond to the Hospital's comments shown in Appendix E.

FYE 12/31/96

1. An adjustment has been calculated for Worksheet B, part III to show the capital to be directly assigned.

2. If the adjustment for Central Supplies was made, there would not be a proper matching of cost (chargeable supplies) and charges (medical supplies charged patients) on line 55 of the cost report. Apparently, in the "as filed" cost report, the Hospital did not reclassify the chargeable supplies to match the revenues reported on line 55. This matter should be brought to the attention of the Hospital's FI.

3. The ancillary charges that the Hospital incorrectly reported as clinic charges have been adjusted to report the charges as ancillary both on Worksheet C and the statistics on Worksheet B- 1 for overhead allocations.

4. A revision the adjustment for the statistics on Worksheet B-l, column 17 is appropriate; and, the adjustments on Worksheet C and the statistics on Worksheet B-l, column 17 have been reconciled.

FYE 12/3 1/97

1. A Worksheet B, part III adjustment has been made for the reimbursable costs directly assigned to capital.

2. Appendix C has been corrected.

3. Charges incorrectly reported under clinic have been shown as ancillary charges on Worksheets C and on the Worksheet B-l statistics.

4. The amount has been adjusted for minor differences; however, the reclassified amounts on line 60 will remain as those amounts reconcile to the general ledger.

5. The Central Supply requisition statistics should be corrected with the FI's assistance

[2]See Appendix E, Pages 4 and 5.

FYE 12/31/98

1. The adjustment has been deleted.

2. Charges incorrectly reported under clinic have been reported as ancillary charges on Worksheets C and on Worksheet B-l statistics.

3. Statistics have been calculated to add to the Medical Records overhead allocation.

4. Worksheet B, Part III has been adjusted to allow the lease expenses to be directly assigned.