DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF AUDIT SERVICES
233 NORTH MICHIGAN AVENUE
CHICAGO, ILLINOIS 60601

REGION V
OFFICE OF
INSPECTOR GENERAL

September 25, 2001

Mr. Nicholas Stokovich, Assistant Administrator
Libertyville Manor Extended Care Facility
6 10 Peterson Road
Libertyville, Illinois 60048

Dear Mr. Stokovich:

Enclosed are two copies of the U.S. Department of Health and Human Services, Office of Inspector General, Office of Audit Services, audit report of Libertyville Manor Extended Care Facility, a Skilled Nursing Facility. A copy of this report will be forwarded to the action official noted below for her review and any action deemed necessary.

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 104-23 1), 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-05-00-0001 1 in all correspondence relating to this report.

Sincerely yours,

Paul Swanson

Paul Swanson
Regional Inspector General
for Audit Services

Enclosures - as stated

**Direct Reply to HHS Action Official:**

Mrs. Dorothy Burk Collins
Regional Administrator
Centers for Medicare and Medicaid Services
233 N. Michigan Ave.
Suite 600
Chicago, IL 60601

Department of Health and Human Services

# OFFICE OF INSPECTOR GENERAL

# AUDIT OF LIBERTYVILLE MANOR EXTENDED CARE FACILITY PROVIDER NUMBER 14-5344

# LIBERTYVILLE, ILLINOIS


**SEPTEMBER 2001**
**A-05-00-0001 1**

DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF AUDIT SERVICES
233 NORTH MICHIGAN AVENUE
CHICAGO, ILLINOIS 60601

REGION V
OFFICE OF
INSPECTOR GENERAL

September 25, 2001

**SUBJECT:** Report on Audit of Libertyville Manor Extended Care Facility
(Provider Number 14-5344)
Common Identification Number A-05-00-000 11

**TO:** Mr. Nicholas Stokovich, Assistant Administrator
Libertyville Manor Extended Care Facility
6 10 Peterson Road
Libertyville, Illinois 60048

This final report provides the results of the audit of Libertyville Manor Extended Care Facility (Libertyville), a Skilled Nursing Facility (SNF). The objectives of the audit were to determine if the costs claimed in the 1997 cost report were in accordance with Medicare guidelines and whether Medicare payments for inpatient therapy services during Calendar Year (CY) 1997 met the Medicare eligibility and reimbursement requirements. Libertyville was paid $506,937 for costs claimed and medical services that did not meet Medicare requirements. They were overpaid $301,603 for costs that are not reimbursable according to Medicare guidelines and $205,334 for claims that did not meet the Medicare eligibility and reimbursement requirements.

We attribute these overpayments to the provider not following applicable Medicare cost reporting principles and billing for therapy services that were not reasonable, medically necessary, or documented in accordance with Medicare reimbursement requirements. Based on the audit results, we have requested that the Fiscal Intermediary (FI) initiate administrative procedures to recover the total overpayment of $506,937.

In a response to our report (see Appendix B), the provider's counsel disputed several of the report conclusions. Since their opinions were the same as expressed during the exit conference and were considered in drafting our initial report, the FI and OIG believe that our final audit determinations are correct. No further adjustment to the report is necessary. The basis for our position is discussed starting on page 6.

## INTRODUCTION

### BACKGROUND

Libertyville was selected for review based on a record of significant therapy charges to Medicare in 1997. An analysis of data, obtained from the Centers for Medicare & Medicaid Services

(CMS) Customer Information System (CIS), identified Libertyville as the highest SNF biller of physical therapy units per Medicare beneficiary during 1997. The provider was also the second largest biller for occupational therapy units per Medicare beneficiary.

The audit was conducted as a joint review with auditors from the Office of Audit Services (OAS) and auditors, analysts, and medical reviewers from the Medicare Fiscal Intermediary (FI), Mutual of Omaha Insurance Company. On site field work was conducted during March and April of 1999.

## SCOPE AND METHODOLOGY

Our audit was conducted in accordance with generally accepted government audit standards. The objectives of the audit were to determine whether 1) the costs claimed on the provider=s 1997 cost report were in accordance with Medicare cost reporting principles and 2) Medicare payments to the provider for inpatient rehabilitation services met the Medicare eligibility and reimbursement criteria.

Auditors from the OIG and FI, jointly conducted a review of the provider=s 1997 cost report to assess the allowability of the expenditures. Medicare reimbursement guidelines and reporting principles were applied to determine whether the costs were reasonable and necessary, related to patient care, and adequately substantiated by the financial records.

We selected this provider from the Illinois Skilled Nursing Facilities listed on the CIS. The FI supplied the 1997 cost report and a file of all claims for physical and occupational therapy charges submitted by the provider during CY 1997. We identified a universe of 152 claims for fifty-five beneficiaries during CY 1997. We reviewed one hundred percent of the claims filed during 1997 or a total of $1,024,339. Due to a change in the therapy services contractor late in 1997, we also selected a judgmental sample of eight additional beneficiaries from the new company. Although the results of this review were outside our audit period, they were reported to reflect the FI decision to seek recovery.

The FI medical experts reviewed the medical files of the 63 Medicare beneficiaries in the two samples. The reviewers used applicable laws, regulations, and Medicare guidelines to determine whether the physical and occupational therapy services rendered by the provider, were medically necessary for the beneficiary's condition, were properly documented in the medical records, and were billed in accordance with Medicare reimbursement requirements.

## RESULTS OF AUDIT

The provider's cost report for 1997 contained costs that were not reasonable and necessary, related to patient care, or adequately supported by the financial records. With its original

submission of the cost report to the FI, the provider requested an additional Medicare reimbursement of $219,398. However, after the audit findings were documented, the FI adjusted the cost report and determined that the provider owed Medicare $301,603.

In addition, our audit of therapy services disclosed that 37 percent of medical claims reviewed were not reasonable and necessary for the beneficiary-s condition. Accordingly, the provider was overpaid $141,867 for services that did not meet the Medicare eligibility and reimbursement requirements. An additional overpayment of $63,467 for medically unnecessary and unsupported services was identified and recommended for recovery by the FI medical review staff.

## PROVIDER COST REPORT ISSUES

The provider submitted Medicare costs totaling $1,769,448 for 1997. We are disallowing $493,009 in costs that were not reasonable and necessary, adequately supported by the financial records, or in accordance with Medicare reporting principles. The disallowed costs apply to medical/patient care, administrative costs, facility operations, bad debts, and reimbursement for denied medical claims.

These costs, described below and presented in Appendix A, were not allocable or reimbursable according to Medicare requirements. The requirements for Medicare financial records are addressed in *42 CFR Section 413.20*, which states that cost-reimbursed providers must maintain sufficient financial documentation to support the costs payable under the Medicare program. The cost report data must be verifiable from the provider's financial records.

The $493,009 in disallowed costs were incorporated into the cost report process by the FI auditor. The step-down calculation resulted in an estimated overpayment by Medicare of $301,603. This was included with a requested refund claimed on the original costs report of $219,398 to arrive at a final cost report settlement amount of $521,001.

### *MEDICAL/PATIENT CARE*

A total of $112,860 in medical/patient care charges, associated with wheel chair fees of $46,566 and charges for support surfaces (air mattresses) of $66,294, were disallowed, and the costs were reclassified to the routine cost area. These costs were deemed to be routine in nature and were reclassified to reflect the proper charge category or were adjusted to agree with total charges.

### *ADMINISTRATIVE COSTS*

The provider claimed $43,961 in unallowable administrative charges for a Marketing Director (salaries of $42,918), which we consider non-reimbursable advertising expense, and advertising expenses of $1,043 that were not supported by invoices.

### *FACILITY OPERATIONS*

The provider submitted $75,335 in unallowable charges for costs of $54,481 unrelated to patient care and $20,854 pertaining to a related entity. These costs were not adequately supported and

are not reported in accordance with the Provider Reimbursement Manual. The provider claimed $21,338 for public utility services, $2,266 for personal vehicle insurance, and real estate taxes of $30,877 that were determined to be unrelated to Medicare patient care. The related entity charges were not supported and did not show that Libertyville Manor incurred or paid for repair expenses of the related facility.

***BAD DEBTS***

Although the provider claimed bad debts of $55,519 on the cost report, it could not support the application of collection policy, could not document reasonable collection efforts, and could not document secondary payor sources. Since collection efforts cannot be supported, the entire amount is disallowed.

***FI REIMBURSEMENT FOR MEDICAL CLAIMS DENIED DURING THE AUDIT AND STANDARD ADJUSTMENTS***

To adjust the cost report for claims denied by medical review, the FI auditors removed overpayments of $205,334 from the cost report. This amount reflects the provider=s Medicare payments for medically unnecessary and unsupported therapy claims. Because the provider and FI agreed that the denied therapy claims would not be collected all at once, the FI could not run a revised Provider Statistical and Reimbursement (PS&R) report and could only estimate the final settlement amount for this fiscal year. Because all the denied claims had not been collected individually and interim payments had been received for these claims, the total amount considered unallowable for medical claims was used to adjust the provider Medicare reimbursable amount.

The FI auditors also adjusted seventeen line items of Medicare data in order to bring the provider's submitted cost report in agreement with Mutual of Omaha=s Provider Statistical and Reimbursement (PS&R) report. This analysis was part of the standard procedures used by the FI auditors when reviewing provider cost reports.

**PROVIDER REHABILITATION SERVICES – MEDICAL ISSUES**

A medical review of the 152 inpatient therapy claims determined that fifty-six claims were paid for therapy services that were not reasonable, medically necessary, or documented in accordance with Medicare reimbursement requirements. This resulted in a disallowance of $141,867.

The conditions for Medicare coverage of rehabilitation services are outlined in Section 214 and 230 of the HCFA Skilled Nursing Facility Manual. For physical and occupational therapy services
to be eligible, the patient must require skilled services on a daily basis and, as a practical matter, these services can be provided only on an inpatient basis. In addition, the services must be:

- furnished, by qualified technical or professional health personnel;
- pursuant to a physician=s orders, with an active written treatment plan;
- provided with the expectation that the condition of the patient will improve materially, in a predictable period of time;

- reasonable and necessary for the treatment of a patient=s illness or injury; and
- reasonable in terms of duration and quantity.

***SERVICES NOT REASONABLE OR MEDICALLY NECESSARY***

The medical review determined that the provider billed for services that were not reasonable or medically necessary for the beneficiary=s condition. Specifically, the provider was reimbursed for services when:

- the patients had no potential for improvement,
- further therapy was not medically reasonable as the patient was not able to benefit and progress,
- the patients did not require the specialized care of a skilled therapist,
- documentation does not support medical necessity for therapy, and
- there was no other skilled service provided to qualify the patient for Medicare coverage.

***DOCUMENTATION NOT IN COMPLIANCE WITH REQUIREMENTS***

The medical record documentation for two claims was missing from the medical files. Medicare eligibility and reimbursement regulations for SNF services require the provider to maintain sufficient medical record documentation to support the services billed.

***ADDITIONAL MEDICAL REVIEW***

During the audit, we became aware of a second therapy contractor being used during the audit period. Because the new contractor began work at the provider in September of 1997, the contractor did not have claims submitted by the provider until CY 1998, after our audit period. Since the new contractor was performing the therapy services for the facility at the time of our site visit, we selected a judgmental sample of claims filed for eight beneficiaries receiving therapy services from the new contractor in order to determine if the high error rate of therapy service claims (37%) continued. The FI medical reviewers examined twenty-eight additional claims billed for $137,588. The reviewers determined that twenty-two claims, seventy-nine percent or a total of $63,467, should be denied.

Given the relatively high rate of denials, we made the therapy contractor and provider aware of the significant increase in medically unnecessary therapy services during the informal exit conference. Because further review of claims was not in the agreed upon scope of work for the joint audit team, we did not review additional services provided by this therapy contractor. However, the provider should take action to review claims submitted by the contractor and implement procedures to stop the overutilization and unsupported therapy services. The FI has initiated action to recover the $63,467 in denied claims.

## RECOMMENDATIONS

We recommend that the CMS instruct the FI to:

- initiate administrative procedures to recover 1997 overpayments for unallowable costs which have been determined to be a total overpayment, after adjustment of $301,603.

- initiate recovery of the denied claims in the amounts of $141,867 and $63,467, respectively.

- direct the provider to ensure that claim costs on future cost reports are properly documented and allowable per the Medicare requirements.

## AUDITEE RESPONSE AND OIG COMMENTS

In its response to our draft report (see APPENDIX B), the provider contends that several of the Report=s conclusions are incorrect. It believes that we should reconsider the financial adjustments to the cost report. Although the provider was given an opportunity to provide additional documentation, not previously considered, the auditee response contained no new explanations or supporting documentation related to the reported financial adjustments and medical review denials. We reviewed all relevant comments made by the provider and believe that our final audit determinations are correct. No further adjustment to our conclusions are necessary. Specific comments and OIG rebuttal follow.

### AUDITEE RESPONSE - MEDICAL / PATIENT CARE

The auditee disagreed with the OIG reclassification of wheel chair costs of $46,566 from the Medical/Patient Care cost report category to routine care. Instead of reporting $46,566 of costs in its originally filed cost report, the provider identified $29,712 of charges for equipment rental and $16,854 in expenses, both in the Medical/Patient Care categories. The auditee questions the amount of the adjustment. The Auditee also disputes an adjustment for air mattresses in the amount of $66,294 and believes that, if an adjustment was appropriate, it should be limited to reported expenses.

### OIG Comments

Although we recognize that the provider has supported these expenses and allocated them based on patient days, the costs are not social service costs. They are routine costs and should be reclassified as such. The $16,854, that was classified as Medical/Patient Care for wheelchairs equipment rental, should be reclassified. The associated revenue of $29,712 for equipment rentals (wheelchairs) was already identified as routine and will continue to reduce routine expenses on worksheet A-8.

Concerning air mattresses, our original draft report was revised to take into account preliminary auditee comments. Our revised adjustment offsets costs by revenues totaling $66,294. This revenue offset was applied against our mattress costs included under Medical/Patient Care and Administrative and General in the amount of $48,406 and $17,888, respectively.

**AUDITEE RESPONSE - ADMINISTRATIVE COSTS – MARKETING DIRECTOR/ADVERTISING EXPENSE**

The auditee disagreed with the full disallowance of the Market Director's salary and contended that the largest portion pertains to allowable admissions and resident care issues. The auditee supplied a description of individual duties and responsibilities of the Marketing Director in an affidavit and contended that $34,334 of the $42,918 was related to reimbursable activities. The auditee also disagreed with the disallowed advertising expenses based on its belief that we overstated the quantifications of invoice amounts.

**OIG Comments**

The salary of the Marketing Director ($42,918) was disallowed due to a lack of documented reimbursable activity for this position. The provider did not have support to determine the actual hours associated with the marketing function of the marketing director's job. The provider supplied an affidavit and an approximate time estimate as support. This is not allowed per the Provider Reimbursement Manual. The provider must have all time studies reviewed by the intermediary, prior to implementation, and obtain their approval of such time studies. The documentation supplied by the provider is not adequate to support the reversal of this adjustment.
In regard to advertising expenses, the provider provided documentation for $26,700 in costs charged on the cost report, while total expenses claimed on the cost report were $27,743. The difference of $1,043 is greater than the support and is not allowable.

**AUDITEE RESPONSE - FACILITY OPERATIONS – PUBLIC UTILITIES/PERSONAL VEHICLES INSURANCE/RELATED ENTITY**

The auditee recognized our adjustment to public utility finding and took no additional exception to the revised Public Utility adjustment. It disagreed with the disallowance of the cost of insurance for two company-owned cars, which it contends were driven by employees for company-related business. The auditee also disagreed with the disallowance of expenses incurred on behalf of the provider by a related entity, SB Holdings. The provider contends that it provided detailed documentation indicating the expenses that were made on behalf of the provider.

**OIG Comments**

Although we recognize that the provider has incurred insurance expenses for these vehicles and that the vehicles are registered, titled, and driven by owners of the company, the provider has not supported that the use of these vehicles was reasonable and necessary and related to patient care.

In regard to the related entity, the expenses were on the financial records of SB Holdings, but the provider did not demonstrate that these expenses were reasonable, necessary, or related to patient care. Therefore, we could not determine the allowability of these expenses.

**AUDITEE RESPONSE - BAD DEBTS**

The auditee did not agree that the bad debts reported in the 1997 cost report should be disallowed because of its inadequate collection efforts.

**OIG Comments**

Although the auditee comments refer to its collection policy and restate its commitment to collection, the provider policy was not being followed and documentation of collection efforts provided during the audit were minimal. We found that the provider did not follow their collection policy, could not document a reasonable collection effort, and could not document secondary payor sources.

**AUDITEE RESPONSE – MEDICAL CLAIMS REVIEW - MEDICAL CLAIMS DENIED**

The auditee disagreed with the conclusions that many of the therapy services were not reasonable or medically necessary or were not documented in accordance with Medicare reimbursement regulations.

**OIG Comments**

Medical review staff from the Fiscal Intermediary, Mutual Of Omaha, examined medical documentation for samples of 152 and 28 claims, respectively. Of these 180 claims, they denied seventy-nine. No additional evidence has been presented to change the medical reviewer's decisions to deny the unreasonable, unnecessary or insufficiently documented claims.

To facilitate identification, please refer to the OIG/OAS Common Identification Number (CIN) A-05-00-0001 1 in any correspondence related to this report.

Paul Swanson

Paul Swanson
Regional Inspector General
for Audit Services

Attachments

**Appendix A**

# COST REPORT ADJUSTMENTS

| NOT IN COMPLIANCE WITH MEDICARE REPORTING PRINCIPLES | | Disallowed costs | Total |
|---|---|---|---|
| *MEDICAL/PATIENT CARE* | | | |
| Wheel Chair | | $16,854 | |
| Revenue Offset for Wheel Chairs | | $29,712 | |
| Support Surfaces | | $66,294 | |
| | | | **$112,860** |
| *ADMINISTRATIVE* | | | |
| Salaries of Marketing Director | | $42,918 | |
| Advertising Expense | | $1,043 | |
| | | | **$43,961** |
| *FACILITY OPERATIONS* | | | |
| Public Utility Charges. | | $21,338 | |
| Insurance for Personal Vehicle | | $2,266 | |
| Real Estate Taxes | | $30,877 | |
| Related Entity Expense | | $20,854 | |
| | | | $75,335 |
| *BAD DEBTS* | | $55,519 | |
| | | | **$55,519** |
| *MEDICAL CLAIMS REVIEW* | | $205,334 | |
| | | | $205,334 |
| **TOTAL UNALLOWABLE COSTS** | | | $493,009 |

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January 23, 2001

**Vin Facsimile & Messenger Delivery**

Ms. Sheri Fulcher
Audit Manager
Office of Audit Services
Department of Health & Human Services
233 North Michigan Avenue
Suite 1360
Chicago, Illinois 60601

***Re: Libertyville Manor Extended Care Facility ("Libertyville Manor") Report (December 2, 2000 A-05-00-00011)***

Dear Ms. Fulcher:

I am writing in response to the Department of Health & Human Services, Office of Inspector General, Office of Audit Services' (the "Department") December 5, 2000 Report (the "Report") regarding the audit that was conducted at Libertyville Manor (Provider Number 14-5344; Common Identification Number A-05-00-0001 1).

After reviewing the Report, we believe that several of the Reports' conclusions are incorrect and mischaracterize Libertyville Manor. The Report indicates that Libertyville Manor was selected for an audit based upon its record of significant therapy charges to the Medicare Program in 1997. The Report states that the Department "identified Libertyville as the highest SNF biller of physical therapy units per Medicare beneficiary during 1997. Libertyville Manor was also the second largest biller for an occupational therapy units per Medicare beneficiary." While Libertyville Manor does not dispute that it provided a significant amount of physical and occupational therapy during 1997 pursuant to valid physicians' orders, Libertyville Manor's increased utilization was the result of its decision to establish a comprehensive therapy program,

In 1997, as part of Libertyville Manor's overall strategic business plan and in response to the financial and business environment which all skilled nursing facilities ("SNF") and nursing facilities encountered during the past few years, she facility converted half a wing of its facility into a therapy wing and established a comprehensive therapy program. Not surprisingly, Libeztyville Manor, a highly regarded SNF located in an educated, upper middle class area which did not have another provider of comprehensive therapy, experienced a significant increase in therapy utilization due to the establishment of its therapy program. As outlined below, we believe that all of the therapy claims were medically necessary and justified. Accordingly, the facility is pursuing appeals of the denied claims,

With regard to the items noted from Libertyville Manor's 1997 cost report, Libertyville Manor disagrees with a significant amount of the adjustments. The Report indicated that there were five broad areas of disallowed costs including medical/patient care, administrative, facility operations, bad debrs, and reimbursement for medical claims denied during the audit. Our comments regarding each of these areas follow.

## Medical/Patient Care

### Reclassification of Costs to the Routine Area (Wheelchairs and Support Surfaces)

The auditors reclassified costs associated with wheelchairs to the routine cost area based on patient days. We reviewed how these costs were originally allocated in the as-filed cost report. In the cost report, $29,712 was identified as income for equipment rentals (wheelchairs). Conversely, an expense of $16,854 was identified in the cost report for equipment rental (wheelchairs). Based on the cost report, a more appropriate adjustment would have been to offset the income up to the expense amount. All additional income should have been allowed. The auditors' adjustment penalizes Libertyville Manor beyond the actual costs incurred.

Libertyville Manor disputes the auditors' adjustment to support surfaces as each air mattress was medically necessary, was ordered by a physician for a specific resident, and met all reimbursement criteria. All support surfaces were ordered for specific residents based upon individual medical need. These costs were clearly ancillary and should be allowed. We provided the auditors with the accountants' work paper which tied back to the expenses in the as-filed cost report, as well as the invoices which demonstrated that each support surface was ordered for a Specific resident and was medically necessary based on his/her condition. We also included documentation demonstrating that each product was ordered under an allowable HCPCs code

and met all requirements for reimbursement. All expenses related to support surfaces claimed in the as-filed cost report are allowable.

While no adjustment was warranted, if one had been appropriate, the amount cited in the Report for support surfaces appears overstated. The Report states that "charges for support surfaces in the amount of $66,294 were adjusted to agree with total charges." The auditors' work papers indicate that only $47,128 (the reported expense) was to be adjusted. The auditor adjusted the expense incurred for support surfaces to an amount equal to the charges for support surfaces. As a direct result of this adjustment, an additional adjustment of $19,166 was included as an offset to A&G. The provider clearly established a distinct revenue and expense account for support surfaces, The remaining charges are incorrectly offset against A&G. As with wheelchair expenses, the adjustment should be limited.

## Administrative Costs

### Marketing Director Salaries

The auditors disallowed Libertyville Manor's marketing director's salary ($42,918) because "the duties of this person are non-reimbursable advertising expenses." The auditors ignored the fact that this individual served as marketing director and admissions coordinator. We reviewed the marketing director/admission coordinator's duties during 1997 to determine the arnount of this individual's time associated with admissions and resident care issues (i.e., reimbursable) and the amount applicable to pure marketing functions (i.e., non-reimbursable). We submitted an affidavit from Joan Seifen who was the marketing director/admission coordinator during 1997. According to her Affidavit, Ms. Seifert devoted approximately 32 hours per week to resident care/admission duties and eight hours per week related to marketing issues. Based on this allocation, the salary of $42,918 should have been adjusted by $8,584 for her marketing duties which results in a total allowable salary of $34,334. We submitted our work papers to the auditors indicating the appropriate adjustments to the salary and the marketing director/admission coordinator's job description outlining her duties with a breakdown of rhe amount of time devoted to these activities. The entire salary should not be disallowed. The amount of $34,334 should be allowed.

### Advertising Expenses

The auditors disallowed an advertising expense because "the provider's invoices do not tie to the amount adjusted or claimed on the cost report." In reviewing the auditors' work papers,

we note that they include two invoices which were actually back up for a third invoice (i.e., they were included in the third invoice) and thus should not have been included in the disallowance. Therefore, the adjustment is overstated. We also note that the auditors added a commission of $430.50 into one invoice that should be subtracted. This information was presented to the auditors. No adjustment is warranted.

**Public Utili ties**

Documentation was provided to the auditors to address confusion regarding charges for public utilities. This confusion was the result of an additional utility service which was added as Libertyville Manor expanded through new construction. This submission resulted in a significant reduction in the adjustment.

## Facility Operations

**"Personal Vehicle" Insurance**

The auditors adjusted Libertyville Manor's general insurance ($2,266) to an "allowable amount" because "the provider has included personal automobile car insurance expense on their cost report for reimbursement." In reviewing the auditors' work papers for this adjustment, they denied costs related to insurance for two cars. Both cars were company vehicles used for the facility. The policies are/were held and paid for by Libertyville Manor, All of the individuals listed on the policies as drivers were employees of Libertyville Manor in 1997. We submitted unambiguous documentation that Libertyville Manor owned both vehicles, including the title of one car and the purchase contract for the second. Additionally, we provided an Affidavir from the Assistant Adminisuator in which he states that both vehicles were owned by Libertyville Manor and used for company-related business. The insurance costs should not be disallowed.

**Related Entity**

We disagree with the auditors' adjustment. The reported expenses are reimbursable. The auditors claimed that they could not properly identify costs attributable to Libertyville Manor but invoiced to a related entity. Detailed documentation indicating that these expenses were on behalf of Libertyville Manor and that they were reimbursable was submitted to the auditors. The auditors either failed to review the detailed documentation or ignored it and disallowed these costs.

## Bad Debts

The auditors disallowed $55,519 from the 1997 cost report. This represents all of the bad debts reported by Libertyville Manor in its cost report. Tn 1997 and in all subsequent cost repotting periods, Libertyville Manor has maintained a policy of pursuing all outstanding accounts regardless of payer type. Staff regularly contact the resident or his or her family to pursue collections on outstanding accounts. Libertyville Manor has consistently made reasonable collection efforts to limit its bad debts. Additionally, it is important to note that Libertyville Manor is a family owned and operated, independent facility and is not Medicaid certified. The majority of Libertyville Manor's bad debts are for private accounts. Therefore, Libertyville Manor has a significant incentive to collect its outstanding debts. Bookkeeping staff are intimately familiar with the accounts and pursue all reasonable means of collection. Because the facility actively pursues the collection of bad debts, the reported bad debts should be allowed.

## Reimbursement for Medical Claims Denied during the Audit

The Report also alleges a problem with provider rehabilitation services-medical issues. Libertyville Manor disagrees with the Report's conclusions that many of the therapy services were not reasonable or medically necessary or were not documented in accordance with Medicare reimbursement regulations. Libertyville Manor asserts that all of the therapy provided was medically necessary and was reasonable. Libertyville Manor further asserts that all therapy services were properly documented. Libertyville Manor is pursuing appeals of all of the denials.

Without agreeing to the accuracy of the Report, and in cooperation with the Department, pursuant to the recommendations made during the audit and in the Report, Libertyville Manor has taken the following action:

1. The bad debt policy has been revised and updated, and staff have been instructed regarding documentation of all attempts to collect on bad debts.

2. The job description of the marketing/admission coordinator has been updated to clearly identify those portions of the job which are devoted to covered services and those which are related to non-covered services to facilitate the cost reporting process. Libertyville Manor has also iniriated a time log for the marketing director/admission coordinator to identify and substantiate reimbursable duties.

3. Libertyville Manor has reviewed those issues raised by the fiscal intermediary and the Department regarding its cost report to ensure that all costs are properly reported.

Thank you for the opportunity to respond to the Report. Please contact me if you have any questions or need additional information.

Very truly yours,

Matthew J. Murer

MJM:jmr

cc: Paul Swanson
Greg Wegner
Paul Vaccaro

CHI61154.1