DEPARTMENT OF HEALTH & HUMAN SERVICES **Office of Inspector General**

Office of Audit Services, Region V
233 North Michigan Avenue
Suite 1360
Chicago, IL 60601

May 12, 2010

Report Number: A-05-08-00053

Mr. Daniel Houston
President
Houston Companies, Inc.
1481 South Grant Avenue
Crawfordsville, IN 47933

Dear Mr. Houston:

Enclosed is the U.S. Department of Health & Human Services (HHS), Office of Inspector General (OIG), final report entitled *Review of Houston Companies Medicaid Cost Reports for Calendar Years 2003, 2004, and 2005*. We will forward a copy of this report to the HHS action official noted on the following page for review and any action deemed necessary.

The HHS action official will make final determination as to actions taken on all matters reported. We request that you respond to this 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.

Section 8L of the Inspector General Act, 5 U.S.C. App., requires that OIG post its publicly available reports on the OIG Web site. Accordingly, this report will be posted at http://oig.hhs.gov.

If you have any questions or comments about this report, please do not hesitate to call me, or contact Lynn Barker, Audit Manager, at (317) 226-7833 ext 21 or through email at Lynn.Barker@oig.hhs.gov. Please refer to report number A-05-08-00053 in all correspondence.

Sincerely,

/James C. Cox/
Regional Inspector General
for Audit Services

Enclosure

Direct Reply to HHS Action Official:

Jackie Garner, Consortium Administrator
Consortium for Medicaid and Children's Health Operations
Centers for Medicare & Medicaid Services
233 North Michigan Avenue, Suite 600
Chicago, IL 60601

cc:
Ms. Pat Nolting, Reimbursement Manager
Indiana Family and Social Services Administration
Office of Medicaid Policy and Planning
402 West Washington Street, Room W382
Indianapolis, IN 46204

Department of Health & Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF HOUSTON COMPANIES MEDICAID COST REPORTS FOR CALENDAR YEARS 2003, 2004, AND 2005

Daniel R. Levinson
Inspector General

May 2010
A-05-08-00053

Office of Inspector General

http://oig.hhs.gov

The mission of the Office of Inspector General (OIG), as mandated by Public Law 95-452, as amended, is to protect the integrity of the Department of Health & Human Services (HHS) programs, as well as the health and welfare of beneficiaries served by those programs. This statutory mission is carried out through a nationwide network of audits, investigations, and inspections conducted by the following operating components:

Office of Audit Services

The Office of Audit Services (OAS) provides auditing services for HHS, either by conducting audits with its own audit resources or by overseeing audit work done by others. Audits examine the performance of HHS programs and/or its grantees and contractors in carrying out their respective responsibilities and are intended to provide independent assessments of HHS programs and operations. These assessments help reduce waste, abuse, and mismanagement and promote economy and efficiency throughout HHS.

Office of Evaluation and Inspections

The Office of Evaluation and Inspections (OEI) conducts national evaluations to provide HHS, Congress, and the public with timely, useful, and reliable information on significant issues. These evaluations focus on preventing fraud, waste, or abuse and promoting economy, efficiency, and effectiveness of departmental programs. To promote impact, OEI reports also present practical recommendations for improving program operations.

Office of Investigations

The Office of Investigations (OI) conducts criminal, civil, and administrative investigations of fraud and misconduct related to HHS programs, operations, and beneficiaries. With investigators working in all 50 States and the District of Columbia, OI utilizes its resources by actively coordinating with the Department of Justice and other Federal, State, and local law enforcement authorities. The investigative efforts of OI often lead to criminal convictions, administrative sanctions, and/or civil monetary penalties.

Office of Counsel to the Inspector General

The Office of Counsel to the Inspector General (OCIG) provides general legal services to OIG, rendering advice and opinions on HHS programs and operations and providing all legal support for OIG's internal operations. OCIG represents OIG in all civil and administrative fraud and abuse cases involving HHS programs, including False Claims Act, program exclusion, and civil monetary penalty cases. In connection with these cases, OCIG also negotiates and monitors corporate integrity agreements. OCIG renders advisory opinions, issues compliance program guidance, publishes fraud alerts, and provides other guidance to the health care industry concerning the anti-kickback statute and other OIG enforcement authorities.

Notices

THIS REPORT IS AVAILABLE TO THE PUBLIC
at http://oig.hhs.gov

Section 8L of the Inspector General Act, 5 U.S.C. App., requires that OIG post its publicly available reports on the OIG Web site.

OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS

The designation of financial or management practices as questionable, a recommendation for the disallowance of costs incurred or claimed, and any other conclusions and recommendations in this report represent the findings and opinions of OAS. Authorized officials of the HHS operating divisions will make final determination on these matters.

EXECUTIVE SUMMARY

BACKGROUND

Pursuant to Title XIX of the Social Security Act (the Act), the Medicaid program provides medical assistance to low-income individuals and individuals with disabilities. The Federal and State Governments jointly fund and administer the Medicaid program. At the Federal level, the Centers for Medicare & Medicaid Services (CMS) administers the program. Each State administers its Medicaid program in accordance with a CMS-approved State plan. Although the State has considerable flexibility in designing and operating its Medicaid program, it must comply with applicable Federal requirements. In Indiana, the Indiana Family and Social Services Administration, Office of Medicaid Policy and Planning (State agency) administers the Medicaid program.

The Indiana Administrative Code (IAC) describes the Medicaid costs that are allowable under the Indiana Medicaid State plan and requires that providers report these costs to the State agency on annual financial reports. If an audit determines that the provider's records do not support cost data submitted to the State agency, appropriate adjustments to the financial reports can be made. The State agency uses the financial reports to establish reimbursement rates.

Houston Companies, Inc. (Houston), a private for-profit organization, owned and operated seven facilities that received Medicaid funding including two nursing homes, five group homes, and a pharmacy located in Crawfordsville and Lebanon, Indiana during calendar years (CY) 2003 through 2005. Houston reported costs totaling $37.7 million on Medicaid financial reports for the nursing homes, group homes, and home office during CYs 2003 through 2005.

OBJECTIVE

Our objective was to determine whether Houston's Medicaid financial reports for CYs 2003 through 2005 accurately reflected costs that were in accordance with Federal and State requirements.

SUMMARY OF FINDINGS

Houston's Medicaid financial reports for CYs 2003 through 2005 did not accurately reflect costs that were in accordance with Federal and State requirements. Houston did not accurately report costs totaling $194,407 on its nursing and group homes and home office financial reports. Specifically, Houston:

- reported $115,544 in unallowable costs,
- reported $52,696 for costs that were not allocable because they were not related to patient care, and
- misclassified reported costs totaling $16,986 and did not report allowable costs totaling $9,181 due to clerical errors.

In addition, Houston's financial reports included potentially unallowable related-party transactions totaling $268,808 for a markup of actual costs for oxygen purchased from its pharmacy.

The financial reports were inaccurate because Houston did not implement sufficient internal controls and procedures to ensure that it reported Medicaid costs that were properly classified and in compliance with Federal and State requirements.

RECOMMENDATIONS

We recommend that Houston:

- submit revised Medicaid financial reports for its nursing homes for CYs 2003 through 2005 and group homes for CY 2004 to the State agency that:
    - reduce costs by $168,240 that were not allowable and allocable,
    - reclassify costs totaling $16,986, and
    - report $9,181 in allowable costs;
- work with the State agency and CMS to determine whether the potentially unallowable related-party transactions should reflect actual costs, thereby reducing reported costs by $268,808; and
- implement internal controls and procedures to ensure that Medicaid financial reports include costs that are properly classified and in accordance with Federal and State requirements.

AUDITEE COMMENTS

In written comments on our draft report, Houston generally disagreed with our findings and said that it will determine whether it is necessary to submit revised financial reports.

Houston's comments are included in their entirety as the Appendix.

OFFICE OF INSPECTOR GENERAL RESPONSE

After reviewing Houston's written comments, we maintain that our findings and recommendations are valid; however, we moved the unreported Medicare Part A therapy revenues to Other Matters, revised subheadings and cost classifications for two findings and reduced unallowable costs by $2,087.

OTHER MATTERS

Houston did not report $1.5 million in Medicare Part A revenue related to physical, speech and occupational therapies on its nursing homes financial reports. State Medicaid financial report instructions (guidance) require providers to report therapy revenue by actual payor source including Medicare. The regulations at 405 IAC 1-14.6-20(b) state that the State agency or its contractor makes an adjustment to remove costs attributable to non-Medicaid therapy services based on an allocation of reported therapy revenues. However, the statute at Indiana Code (IC) 12-15-14-2(b) states that the State agency may not require a provider to submit non-Medicaid revenue information in the provider's annual historical financial report. While this revenue information may be obtained through audits, it may not be used for public reporting purposes. The statute conflicts with both the regulations and guidance. Since the statute takes precedence over regulations and guidance, we cannot recommend Houston report $1.5 million in Medicare Part A revenues on its financial reports.

TABLE OF CONTENTS

INTRODUCTION

BACKGROUND

Pursuant to Title XIX of the Social Security Act (the Act), the Medicaid program provides medical assistance to low-income individuals and individuals with disabilities. The Federal and State Governments jointly fund and administer the Medicaid program. At the Federal level, the Centers for Medicare & Medicaid Services (CMS) administers the program. Each State administers its Medicaid program in accordance with a CMS-approved State plan. Although the State has considerable flexibility in designing and operating its Medicaid program, it must comply with applicable Federal requirements. In Indiana, the Indiana Family and Social Services Administration, Office of Medicaid Policy and Planning (State agency) administers the Medicaid program.

Federal Requirements

Section 1902(a)(30)(A) of the Social Security Act (the Act)) requires that states assure that payments to providers are "consistent with efficiency, economy and quality of care . . . " Section 1902(a)(13)(A) of the Act) also requires that a public process be used to determine rates for institutional providers such as nursing homes. Finally, section 1902(a)(27) of the Act requires that States enter into provider agreements that require providers to keep such records as are necessary to document the services provided to Medicaid beneficiaries.

Indiana Administrative Code Requirements

The Indiana Administrative Code (IAC) establishes the requirements for providers to report income and expenses on annual Medicaid financial reports. 405 IAC 1-12 covers the rate-setting criteria for group homes. 405 IAC 1-14.6 covers the rate-setting criteria for nursing facilities. Pursuant to 405 IAC 1-12-10(c) and 405 IAC 1-14.6-10(b), providers report as patient care costs only those costs incurred while providing patient care services. Providers certify that costs not related to patient care were separately identified on the financial report. Pursuant to 405 IAC 1-12-4(a) and 405 IAC 1-14.6-4, each provider shall submit an annual financial report to the State agency.

Pursuant to 405 IAC 1-12-3(f) and 405 IAC 1-14.6-3(f), providers must file a home office financial report annually that reports home office costs, if the provider has multiple facilities or is part of a parent organization. Allocated costs that are incurred at a home office must be properly recorded and submitted on the home office financial report in order to be included on other facilities' financial reports. The State agency uses the financial reports to establish reimbursement rates for nursing homes and group homes throughout the State of Indiana. However, each provider has its own reimbursement rate based on the financial report filed with the State agency.

Pursuant to 405 IAC 1-12-3(b) and 405 IAC 1-14.6-3(b), a provider must maintain financial records for a period of 3 years after the date of submission of financial reports to the State agency. The provider's accounting records must establish an audit trail to the financial reports submitted to the State agency. Pursuant to 405 IAC 1-12-3(c) and 405 IAC 1-14.6-3(c), if an

audit determines that the provider's records do not support cost data submitted to the State agency, the State agency must present the provider with a list of deficiencies and give the provider 60 days to correct the deficiencies. If the provider fails to correct the deficiencies within the 60 day period the State agency may make appropriate adjustments to the financial reports.

Houston Companies Organizational and Corporate Structure

Houston Companies, Inc. (Houston), a private for-profit company, owned and operated seven facilities that received Medicaid funding including two nursing homes and five group homes during calendar years (CY) 2003 to 2005, as well as a home office. Houston is comprised of the following five corporations:

- Houston Companies, Inc. (Home Office) is the home office located in Crawfordsville, Indiana.
- DHE, Inc., doing business as Ben Hur nursing home (Ben Hur), is a Medicaid-related nursing home located in Crawfordsville, Indiana.
- Houston Development, Inc., doing business as Williamsburg nursing home (Williamsburg), is a Medicaid-related nursing home located in Crawfordsville, Indiana.
- Houston Group Homes, Inc. consists of five group homes including Cedar Pointe, located in Lebanon, Indiana; Market Hall, located in Crawfordsville, Indiana; Penn Hall, located in Crawfordsville, Indiana; Pine Ridge, located in Lebanon, Indiana; and White Hall, located in Crawfordsville, Indiana.
- Village Drug Store, Inc. (Village Drug Store) located in Crawfordsville, Indiana, supplies prescription drugs and other medical supplies primarily to Houston's nursing homes and group homes and their patients.

Houston submitted annual Medicaid financial reports for the home office, nursing homes, and group homes during CYs 2003 through 2005. During this period, Houston reported Medicaid costs totaling $37.7 million.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether Houston's Medicaid financial reports for CYs 2003 through 2005 accurately reflected costs that were in accordance with Federal and State requirements.

Scope

We reviewed Houston's nursing homes (Ben Hur and Williamsburg) and home office Medicaid financial reports which identified costs totaling $31.7 million for CYs 2003 through 2005. We limited our review of group homes (Cedar Pointe, Market Hall, Penn Hall, Pine Ridge, and White Hall) to Medicaid financial reports that identified costs totaling $2 million for CY 2004

because the 2004 financial reports were the only reports used by the State agency to recalculate Medicaid rates during the audit period.

We limited our internal control review to Houston's policies, procedures, and controls over reporting revenues and costs reported on the Medicaid financial reports for CYs 2003 through 2005.

We performed fieldwork at Houston's home office in Crawfordsville, Indiana.

Methodology

To accomplish our objective, we:

- reviewed applicable Federal and State laws, regulations, and guidelines;
- reviewed Houston's policies and procedures related to reporting revenues and Medicaid expenses on its financial reports;
- reconciled the financial reports to supporting documentation and accounting records for CYs 2003 through 2005;
- interviewed Houston officials and State agency representatives to identify and understand policies and procedures for completing and reviewing Medicaid financial reports;
- traced judgmentally selected transactions totaling $3,356,979 to payroll reports, canceled checks, timesheets, pay notices, vouchers, invoices, and other supporting documentation;
- reviewed bonuses and hours worked summaries to determine if bonuses and hours paid were in accordance with Houston's policy;
- used Medicare claims payment information to summarize the covered therapy services by therapy revenue codes and facility to determine whether the Medicare Part A revenue was reported on the Medicaid Financial Report, Schedule D, as required;[1]
- reviewed the details of the related-party transactions, including the State agency letter approving the related-party exception for the Village Drug Store;
- compared the oxygen expenses in the Village Drug Store accounting records to the oxygen expenses in the nursing homes' accounting records to calculate the markup on oxygen provided by the Village Drug Store; and
- computed cost adjustments for nursing and group homes and coordinated the results of our audit with Houston and State agency representatives.

[1] Schedule D is a schedule of revenue, which is used to report all revenue from facility operations, including routine and ancillary revenue from all payor sources.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objective. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objective.

FINDINGS AND RECOMMENDATIONS

Houston's Medicaid financial reports for CYs 2003 through 2005 did not accurately reflect incurred costs that were in accordance with Federal and State requirements. Houston did not accurately report costs totaling $194,407 on its nursing and group homes and home office financial reports. Specifically, Houston:

- reported $115,544 in unallowable costs,
- reported $52,696 for costs that were not allocable because they were not related to patient care, and
- misclassified reported costs totaling $16,986 and did not report allowable costs totaling $9,181 due to clerical errors.

In addition, Houston's financial reports included potentially unallowable related-party transactions totaling $268,808 for a markup of actual costs for oxygen purchased from its pharmacy.

The financial reports were inaccurate because Houston did not implement sufficient internal controls and procedures to ensure that it reported Medicaid costs that were properly classified and in compliance with Federal and State requirements.

UNALLOWABLE COSTS

Federal and State Requirements

Pursuant to section 1919(d)(4)(A) of the Social Security Act, a nursing facility must operate and provide services in compliance with all applicable Federal, State, and local laws and regulations.

Pursuant to 405 IAC 1-4.3-1(b), legal fees, expenses related to expert witnesses, accounting fees, and other consulting fees shall not be reimbursed by the office as reasonably related medical expenses under the Medicaid program if the expenses are incurred as the result of an administrative or judicial action or proceeding against any agency of the state or the federal government.

Pursuant to 405 IAC 1-14.6-14(e), the cost of a single asset or collection of like assets, acquired in quantity, including permanent betterment or improvements, has at the time of acquisition an

estimated useful life of at least 3 years and a historical cost of at least $500, shall be capitalized and included in the property basis for the approved useful life of the asset.

Pursuant to 405 IAC 1-12-3(b) and 405 IAC 1-14.6-3(b), a provider must maintain accounting records that establish an audit trail from those records to the financial reports submitted to the State agency. Also, 405 IAC 1-12-2(z) and 405 IAC 1-14.6-2(bb) state that a reasonable allowable cost is the price a prudent, cost-conscious buyer would pay a willing seller for goods or services in an arm's length transaction.[2]

Unallowable Costs Reported

Houston reported $115,544 for unallowable costs related to legal fees, real estate and property taxes, equipment not capitalized, and a traffic ticket on its financial reports for CYs 2003 through 2005.

Table 2: Summary of Unallowable Costs Reported

Unallowable Costs	2003	2004	2005	Total
Legal Fees	$0	$42,125	$51,717	**$93,842**
Real Estate and Property Taxes	0	(320)	11,760	**11,440**
Office and Building Equipment Not Capitalized	3,248	6,547	0	**9,795**
Traffic Ticket	0	0	467	**467**
Total	**$3,248**	**$48,352**	**$63,944**	**$115,544**

Legal Fees

Houston reported unallowable costs totaling $93,842 on Ben Hur nursing home's financial reports ($37,715 for 2004 and $51,717 for 2005) and the 2004 Home Office financial report ($4,410) for legal fees associated with a 2004 Indiana State Department of Health survey that gave the Ben Hur nursing home an unsatisfactory rating. As a result of the survey, CMS imposed civil monetary penalties on Houston. Houston did not provide adequate documentation to indicate that these fees were not incurred as a result of an administrative or judicial action or proceeding against an agency of the state or federal government.

Pursuant to 405 IAC 1-4.3-1(b), the legal fees associated with the 2004 survey were unallowable.

[2] These regulations were in effect during our audit period. Regulations at 405 IAC 1-12-2(z) and 405 IAC 1-14.6-2(bb) were amended on October 10, 2002 and July 29, 2003, respectively and are now located at 405 IAC 1-12-2(bb) and 405 IAC 1-14.6-2(cc).

Unsupported Real Estate and Property Taxes

Houston overstated real estate and property taxes by $11,440 on the Ben Hur nursing home financial report ($169 for 2004 and $8,731 for 2005) and on the Williamsburg nursing home financial report (($489) for 2004 and $3,029 for 2005). These costs were unallowable because the reported taxes were not supported by the tax statements.

Office and Building Equipment Not Capitalized

Pursuant to 405 IAC 1-14.6-14(e), the cost of assets over $500 is required to be capitalized. Houston reported unallowable costs totaling $9,795 for office and building equipment that should have been capitalized on the nursing homes and home office financial reports. The office and building equipment included: $2,344 for repairing a nurse station alarm system; $1,821 for a time clock system; $1,409 for a steel door; $1,375 for sprinkler system repairs; $973 for building expenses; $953 for purchase of a computer; and $920 for a mobile phone.

Table 3: Unallowable Office and Building Equipment Costs

Financial Report	2003	2004	2005	Total
Williamsburg	$2,328	$4,726	$0	$7,054
Ben Hur	0	1,821	0	1,821
Home Office	920	0	0	$920
Total	$3,248	$6,547	$0	$9,795

The cost of these assets exceeded $500 and therefore, should have been capitalized.

Traffic Ticket

Houston reported $467 on the Williamsburg nursing home 2005 financial report for a traffic ticket on its laundry truck. Pursuant to section 1919(d)(4)(A) of the Social Security Act, this cost is unallowable because Houston did not operate the truck in compliance with all Federal, State, and local laws and regulations.

COSTS NOT ALLOCABLE AND RELATED TO PATIENT CARE

State Requirements

For reporting allocable costs, 405 IAC 1-14.6-10(b) states that the provider shall report as patient care costs only costs that have been incurred in the providing of patient care services. The provider shall certify on all financial reports that costs not related to patient care have been separately identified on the financial report.

Costs Not Allocable to Medicaid-Related Facilities and Activities

Houston reported $52,696 in expenses that were not allocable to its Medicaid-related facilities because the costs were not related to patient care services. These costs included personal mortgage interest, expenses related to Houston's non-Medicaid facilities, utility expenses for the

Village Drug Store, lease payments for a personal vehicle, utility and inspection expenses for a non-operational facility, costs for vehicles not used for patient care, and employee overtime paid for hours not associated with patient care.

Table 4: Summary of Costs Not Allocable

Costs	2003	2004	2005	Total
Mortgage Interest and Insurance For Rental Properties	$4,445	$8,225	$7,384	**$20,054**
Non-Medicaid Facilities	64	11,840	250	**12,154**
Village Drug Store Utilities	1,416	1,483	1,568	**4,467**
Personal Vehicle Lease	0	6,581	0	**6,581**
Non-Operational Facility	26	375	3,513	**3,914**
Vehicles Not Used For Patient Care	534	1,060	1,151	**2,745**
Overtime Paid Not Associated With Patient Care	1,080	1,060	641	**2,781**
Total	**$7,565**	**$30,624**	**$14,507**	**$52,696**

Mortgage Interest and Insurance for Rental Properties

Houston reported $20,054 on the home office and Ben Hur nursing home financial reports for mortgage interest ($8,588) and insurance policies ($11,466) for rental properties.

Table 5: Mortgage Interest and Insurance Costs Not Allocable

Financial Report	2003	2004	2005	Total
Home Office	$263	$5,561	$5,642	**$11,466**
Ben Hur	4,182	2,664	1,742	**8,588**
Total	**$4,445**	**$8,225**	**$7,384**	**$20,054**

Since these costs were unrelated to Medicaid patient care, the costs were not allocable to Houston's Medicaid activities.

Non-Medicaid-Related Facilities

Houston reported $12,154 on the home office financial reports for raw food expenses ($11,840), bonuses ($250), and repairs ($64) related to Houston's private, non-Medicaid-related facilities for CYs 2003 through 2005.

Table 6: Non-Medicaid Facilities Costs Not Allocable

Costs	2003	2004	2005	Total
Raw Food	$0	$11,840	$0	**$11,840**
Bonuses	0	0	250	**250**
Repairs	64	0	0	**64**
Total	**$64**	**$11,840**	**$250**	**$12,154**

Since these costs were not related to Medicaid patient care, the costs were not allocable to Houston's Medicaid activities.

Village Drug Store

Houston reported $4,467 on the Ben Hur nursing home financial reports for CYs 2003 ($1,416), 2004 ($1,483), and 2005 ($1,568) for the Village Drug Store's utility expenses which were not directly associated with Medicaid patient care activities. Since these costs were not related to Medicaid patient care, the costs were not allocable to Houston's Medicaid financial reports.

Owner's Personal Vehicle

Houston did not remove $6,581 from the Ben Hur nursing home financial report for 2004 for lease payments related to a personal vehicle. The vehicle was registered in the owner's name and not Ben Hur. Since these costs were not related to Medicaid patient care, the costs were not allocable to Houston's Medicaid financial report.

Non-Operational Facility

Houston reported $3,914 on the Ben Hur nursing home financial reports for 2003 ($26), 2004 ($375) and 2005 ($3,513) for utility expenses and inspections related to a non-operational facility, which Houston had closed in 2002. Since these costs were not related to Medicaid patient care, the costs were not allocable to Houston's Medicaid financial reports.

Vehicles Not Used for Patient Care

Houston reported $2,745 related to vehicles costs on the home office financial reports for CYs 2003 through 2005 and on the Williamsburg nursing home financial reports for CYs 2004 and 2005. The costs included license plates for vehicles that were registered to Ben Hur nursing home, but were not used for patient care.

Table 7: Costs Reported for Vehicles Unrelated to Medicaid Patient Care

Financial Report and Associated Expenses	2003	2004	2005	Total
Home Office -License Plates	$534	$537	$679	**$1,750**
Williamsburg -License Plates	0	523	472	**995**
Total	**$534**	**$1,060**	**$1,151**	**$2,745**

Since these costs were not related to Medicaid patient care, the costs were not allocable to Houston's Medicaid financial reports.

Employee Overtime and Materials Not Related to Patient Care

Houston reported $2,781 for employees' paid overtime for hours not associated with patient care and returned employee materials.

Table 8: Overtime and Materials Unrelated to Medicaid-Patient Care

Financial Report and Associated Expenses	2003	2004	2005	Total
Williamsburg – Overtime	$1,017	$946	$521	**$2,484**
Ben Hur - Overtime	43	114	88	**245**
Home Office - Overtime	0	0	32	**32**
Williamsburg - Employee Materials	**20**	**0**	**0**	**20**
Total	**$1,080**	**$1,060**	**$641**	**$2,781**

Since these costs were not related to Medicaid patient care, the costs were not allocable to Houston's Medicaid financial reports.

MISCLASSIFIED REPORTED COSTS AND UNREPORTED COSTS

State Requirements

State regulations (405 IAC 1-12-3(a) and 405 IAC 1-14.6-3(a)) require that providers adhere to generally accepted accounting principles, which requires accurate and consistent classification of financial information.

Misclassified and Unreported Costs

Houston incorrectly classified costs totaling $16,986 and did not report allowable costs totaling $9,181 on the Medicaid financial reports. Specifically, Houston:

- incorrectly reported $7,668 for drugs and vaccines as routine medical supplies, which should have been reported as pharmacy or drug expenses on the 2005 financial reports for Ben Hur nursing home ($5,074) and Williamsburg nursing home ($2,594);

- reported $4,815 for interest and depreciation expenses on the incorrect line on the Ben Hur nursing home financial report for 2004;

- incorrectly reported $4,503 for utilities expenses on the Ben Hur nursing home financial report instead of the five group homes and the home office financial reports for 2003 ($1,416), 2004 ($1,519), and 2005 ($1,568); and

- did not report $9,181 for allowable costs on the Williamsburg nursing home financial reports for 2003 ($1,603), 2004 ($5,570), and 2005 ($1,801) and on Market Hall group home financial report for 2004 ($207) due to clerical errors.

POTENTIALLY UNALLOWABLE RELATED-PARTY TRANSACTIONS

State Requirements

Pursuant to 405 IAC 1-14.6-11(a), costs applicable to services, facilities, and supplies furnished to the provider by organizations related to the provider by common ownership or control may be included in the allowable cost in the unit of service of the provider at the cost to the related organization. However, such costs must not exceed the price of comparable services, facilities, or supplies that could be purchased elsewhere in an arm's-length transaction.

Pursuant to 405 IAC 1-14.6-11(e) an exception shall be granted when a related organization meets conditions including a sufficient part of the supplying organization's business activity is transacted with other than the provider and organizations related to the supplier in common ownership or control, and there is an open competitive market for the type of services, facilities, or supplies furnished by the organization.

Oxygen Purchases

Houston reported potentially unallowable markup costs totaling $268,808 for oxygen purchased from its pharmacy, the Village Drug Store, on the Ben Hur and Williamsburg nursing home financial reports for CYs 2003 through 2005. The State agency granted Houston a related-party exception for its pharmacy. However, our audit showed that the majority of the pharmacy's business was with Houston's nursing home residents. This appears to be contrary to the requirements for granting a related-party exemption. We set aside the markup costs for further review by the State agency and CMS.

Table 9: Markup on Village Drug Store Oxygen Purchases

Financial Report	2003	2004	2005	Total
Ben Hur	$27,286	$19,268	$15,993	**$62,547**
Williamsburg	58,111	76,403	71,747	**206,261**
Total	**$85,397**	**$95,671**	**$87,740**	**$268,808**

HOUSTON INTERNAL CONTROLS

The financial reports were inaccurate because Houston did not implement sufficient internal controls and procedures to ensure that it reported Medicaid costs in compliance with Federal and State requirements.

RECOMMENDATIONS

We recommend that Houston:

- submit revised Medicaid financial reports for its nursing homes for CYs 2003 through 2005 and group homes for CY 2004 to the State agency that:
    - reduce costs by $168,240 that were not allowable and allocable,
    - reclassify costs totaling 16,986, and
    - report $9,181 in allowable costs;
- work with the State agency and CMS to determine whether the potentially unallowable related-party transactions should reflect actual costs, thereby reducing reported costs by $268,808; and
- implement internal controls and procedures to ensure that Medicaid financial reports include costs that are properly classified and in accordance with Federal and State requirements.

OTHER MATTERS

Houston did not report $1.5 million in Medicare Part A revenue related to physical, speech and occupational therapies on its nursing homes financial reports. State Medicaid financial report instructions (guidance) require providers to report therapy revenue by actual payor source including Medicare. The regulations at 405 IAC 1-14.6-20(b) state that the State agency or its contractor makes an adjustment to remove costs attributable to non-Medicaid therapy services based on an allocation of reported therapy revenues. However, the statute at Indiana Code (IC) 12-15-14-2(b) states that the State agency may not require a provider to submit non-Medicaid revenue information in the provider's annual historical financial report. While this revenue information may be obtained through audits, it may not be used for public reporting purposes. The statute conflicts with both the regulations and guidance. Since the statute takes precedence

over regulations and guidance, we cannot recommend Houston report $1.5 million in Medicare Part A revenues on its financial reports.

AUDITEE COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, Houston generally disagreed with our findings and said that it will determine whether it is necessary to submit revised financial reports

A summary of Houston's comments and our related response follows. Houston's comments are included in their entirety as the Appendix,

Unallowable Costs

Houston Comments – Legal Fees

Houston maintained that the administrative review of survey findings was not a civil proceeding. As a result, the associated legal fees are allowable. In addition, Houston said that it did not report $51,717 in unallowable legal fees on the Ben Hur 2005 financial report, but removed $58,310 in legal fees from its 2005 financial report. Consequently, Houston underreported legal fees by $6,593.

Office of Inspector General Response – Legal Fees

Pursuant to 405 IAC 1-4.3-1(b), legal fees shall not be reimbursed if the expenses are incurred as the result of an administrative action or proceeding against any agency of the state or federal government.

In 2005, Houston reported $110,027 related to the 2004 survey; however, Houston properly removed $58,310 from the financial report. The remaining $51,717 for legal fees in 2005 is unallowable, as well as the $2,125 in survey-related legal fees reported in 2004. Houston did not provide adequate documentation to indicate that these fees were not incurred as a result of an administrative or judicial action or proceeding against an agency of the state or federal government. Accordingly, reported legal fees in 2004 and 2005 are unallowable.

Costs Not Allocable and Related to Patient Care

Houston Comments – Personal Mortgage Interest and Insurance for Owner's Personal Rental Properties

Houston asserted that it did not report personal mortgage interest or insurance for personal rental properties on the Medicaid financial reports. The rental properties were single family residences owned by Ben Hur and rented to employees and non-employees. The personal property consisted of two leased vehicles and construction equipment owned by Houston.

Office of Inspector General Response – Personal Mortgage Interest and Insurance for Owner's Personal Rental Properties

We omitted the word "Personal" from the subheading for this finding. For reporting allocable costs, 405 IAC 1-14.6-10(b) states that the provider shall report as patient care costs only costs that have been incurred in the providing of patient care services. The provider shall certify on all financial reports that costs not related to patient care have been separately identified on the financial report. Per cost report instructions for Schedule E "Schedule of Expenses", provider adjustments must be made on Column [24] to include, but not limited to, the removal of non-patient related costs from Columns [02] and [03].

Houston did not adjust these non related patient care costs on column [24] of the Medicaid cost reports.

Houston Comments – Village Drug Store

Houston disagreed with the utility adjustments for the Village Drug Store for 2003 and 2005. Houston recommended that half of these adjustments for 2003 and 2005 be reported under "Misclassified Reported Costs" instead of "Costs Not Allocable." Houston agreed with the remaining adjustments.

Office of Inspector General Response – Village Drug Store

We reclassified one-half of the utility adjustments as "Misclassified Reported Costs" instead of "Costs Not Allocable" after considering Houston's comments.

Houston Comments – Owner's Personal Vehicle

Houston asserted that it correctly reported the owner's personal vehicle on the 2004 financial report and removed $4,815 on the 2004 financial report adjustments column. Consequently, Houston only reported $1,766 for lease payments on the 2004 financial report.

Office of Inspector General Response – Owner's Personal Vehicle

Pursuant to 405 IAC 14.6-8(b), each facility shall be allowed only one patient care related vehicle. The financial report instructions state that all expenses associated with non-allowable vehicles should be removed. Per cost report instructions for Schedule E "Schedule of Expenses", provider adjustments must be made on Column [24] to include, but not limited to, the removal of non-patient related costs from Columns [02] and [03] including the removal of expenses associated with non-allowable vehicles.

We agreed that Houston removed $4,815 on the 2004 financial report; however, this amount represented the purchased vehicle, not the leased vehicle. We considered the $4,815 as misclassified costs. Houston made a clerical error and did not remove the leased vehicle costs totaling $6,581 on the financial report.

Houston Comments – Vehicles Not Used for Patient Care

Houston did not dispute the vehicle cost adjustments but disagreed with the cost of the fine for a traffic ticket adjustment related to a patient-related laundry truck. The ticket was a result of not displaying correct signage on the outside, unsecured fire extinguisher, horn inoperative, no battery box cover, seat belt violation, and other various infractions.

Office of Inspector General Response – Vehicles Not Used for Patient Care

Section 1919(d)(4)(A) of the Social Security Act states a nursing facility must operate and provide services in compliance with all applicable Federal, State, and local laws and regulations and with accepted professional standards and principles which apply to professionals providing services in such a facility. Houston failed to follow state laws when it received the ticket, therefore the cost of the fine for the ticket is unallowable. We agree with Houston that the laundry truck was a patient-related vehicle and moved the traffic ticket of $467 to the Unallowable Cost section of the report.

Houston Comments – Employee Overtime and Materials Not Related to Patient Care

Houston disagreed that the employee hours were not associated with patient care.

Office of Inspector General Response – Employee Overtime and Materials Not Related to Patient Care

We verified that the employee overtime costs included cleaning the owner's house and other activities that were not associated with patient care. These costs remain unallowable.

Potentially Unallowable Related-Party Transactions

Houston Comments – Potentially Unallowable Related-Party Transactions

Houston disagreed that the Village Drug Store did not meet the related party exception. The State agency had determined that Houston had met the condition to qualify for a related party exception and granted a related party exception the past several years.

Office of Inspection General Response – Potentially Unallowable Related-Party Transactions

Regulations at 405 IAC 1-14.6-11(e)(2) state that the related party exception applies if, a sufficient part of the supplying organization's business activity is transacted with other than the provider and organizations related to the supplier in common ownership or control, and there is an open and competitive market for the type of services, facilities, or supplies furnished by the organization. However, our audit showed that the majority of Village Drug Store's business is comprised of Houston's patients. This appears to be contrary to the requirements for granting a related-party exemption. Accordingly, we set aside the oxygen markup costs for further review by the State agency and CMS.

Unreported Part A Revenues

Houston Comments

Houston said that it did not report the Medicare Part A therapy revenue because Part A therapies are not reimbursed separately from the per diem rate and thus, there is no revenue to record for Medicaid Part A therapy services. Houston relied on the IC 12-15-14-2(b) and financial report instructions to exclude the therapy revenue from the Medicaid financial report, since this revenue is part of the routine income and not clearly identifiable.

Office of Inspector General Response

The statute conflicts with both the regulations and guidance, as it does not require providers to report non-Medicaid revenue information on the Medicaid cost report. We have moved the unreported part A revenues issue to Other Matters section of the report.

APPENDIX

APPENDIX: AUDITEE COMMENTS

HOUSTON COMPANIES, INC.
HEALTH CARE PROVIDERS SINCE 1956
1481 SOUTH GRANT AVENUE
P. O. BOX 661
CRAWFORDSVILLE, INDIANA 47933
PHONE: (765) 362-0905 – FAX: (765) 362-1268

August 27, 2009

Marc Gustafson, Regional Inspector General for Audit Services
Department of Health and Human Services
Office of Audit Services
233 North Michigan Avenue
Chicago, IL 60601

Re: Written comments regarding Report Number: A-05-08-00053

Mr. Gustafson,

Enclosed please find Houston Companies' written comments regarding the OIG draft report entitled "Review of Houston Companies Medicaid Cost Reports for Calendar Years 2003, 2004, and 2005."

In Indiana, Medicaid nursing homes must submit cost reports to Myers and Stauffer, an independent CPA firm contracted by Indiana to set Medicaid rates for nursing homes. Myers thoroughly reviews these cost reports and then sets nursing homes' per diem Medicaid rates based on a complex payment criteria established in regulation. No cost in a nursing home is treated as a pass through in Indiana. All costs are subject to rate limiters, minimum occupancy thresholds, and other rate components that affect the per diem Medicaid rate. In other words, saying a provider reported $117,164 in unallowable cost does not mean the provider received this amount in its per diem Medicaid rate. If the per diem rates were recalculated without these costs, the rate impact would be much less.

Additionally, Indiana Medicaid nursing homes are audited routinely by an independent CPA firm. Prior to the OIG audit, Clifton Gunderson audited Houston for Calendar Years 2003 and 2004. The items cited in the OIG audit were not cited in the Clifton audit, even though they both audited 2003-2004.

FINDINGS AND RECOMMENDATIONS

- Houston disagrees that it did not report $1.5 million in Medicare Part A revenues. Table 1 on page 5 of the draft audit is not revenue, it is charges that Houston is

required to bill for government data collection purposes only, and it has no affect on the amount of Medicare Part A revenue Houston received.

- Houston agrees it reported $11,440 in unallowable costs but does not agree the remaining $105,724 is unallowable costs. Table 2 on page 6 of the draft audit summarizes four components totaling $117,164. Houston agrees the Real Estate and Property Taxes were understated in 2004 and overstated in 2005. Houston disagrees the Office and Building Equipment Not Capitalized was "unallowable costs". Houston agrees the costs should have been capitalized but were misclassified and recommends Office and Building Equipment Not Capitalized be removed from Table 2 and that Table 3 be reported under Misclassified Reported Costs and Unreported Costs on page 10 of the draft audit report. Houston disagrees the Legal Fees and Vehicle Accident costs are unallowable.

- Houston agrees it reported $45,120 in costs not allocable but does not agree the remaining $11,027 is not allocable. Table 4 on page 8 of the draft audit report summarizes seven components totaling $56,147 in costs not allocable because the OIG alleged they were not related to patient care. Houston disagrees with the Village Drug Store Utilities for 2003 and 2005. Houston recommends ½ of the Village Drug Store Utilities for 2003 and 2005 be removed from Table 4 and reported under Misclassified Reported Costs and Unreported Costs on page 10 of the draft audit report and allocated to the group home cost reports for 2003 and 2005. Houston understands this will not impact group home rates for 2003 and 2005, but the amount reported on Table 4 for 2003 and 2005 is incorrect, inconsistent with the method the OIG used for 2004, and misleading. Houston disagrees with the Personal Vehicle Lease cost. On its filed 2004 Cost Report Schedule E, Column 4, Houston reported $1,766 for the leased automobile. Except for the Overtime Paid Not Associated with Patient Care and the traffic ticket, Houston agrees with the remaining components.

- Other than the Office and Building Equipment Not Capitalized and ½ Village Drug Store Utilities being reported under Misclassified Reported Costs and Unreported Costs on page 10 of the draft audit report, Houston agrees with the misclassified and unreported costs due to clerical errors.

Houston disagrees it filed Cost Reports with potentially unallowable related party transactions. As permitted by Indiana regulation, Houston requested and received a related party exception from the State.

UNREPORTED PART A REVENUES

The Balanced Budget Act of 1997 mandated the implementation of a per diem prospective payment system (PPS) for skilled nursing facilities (SNFs) covering **all** costs (routine, ancillary and capital) related to the services furnished to beneficiaries under Part A of the Medicare program. Part A therapies are not reimbursed separately from the per diem rate thus there is no revenue to record for Medicare Part A therapy service. The

draft audit report states Houston failed to report 1.5 million in Medicare Part A revenue for therapy services during the audit period. Houston did not receive separate reimbursement for Medicare Part A therapy services; if it had it would have violated the BBA of 1997 referenced above.

SNFs are required to bill for therapies and other ancillary items on a Medicare billing form (UB-04), but they are not reimbursed for these charges. SNFs are required to bill inputted charges for these items for government collection purposes only; they have no affect on the Medicare Part A per diem a SNF receives. The amounts listed on Table 1 are not revenue we received providing Part A therapy and it is inaccurate and very misleading to list them as such.

Houston did report Ben Hur's and Williamsburg's revenues in conformance with IC 12-15-14-2 (b), 405 IAC 1-14.6-4(c) (4) as well as page 5 of the Instructions for the Medicaid Nursing Facility Financial Report (Rev. 7/06) which are attached (Exhibit 1-3). IC 12-15-14-2 (b) states "The office may not require a provider to submit non-Medicaid revenue information in the provider's annual historical financial report." 405 IAC 1-14.6-4(c) (4) states a provider must disclose "Statement of all expenses and all income, excluding non-Medicaid routine income." On the Instructions for the Medicaid Nursing Facility Financial Report, Schedule D – Schedule of Revenue (page 5), the bottom paragraph states "...Although the criteria requires therapy, non-routine medical supply items, and Parenteral and Enteral Nutrition (PEN) items to be reimbursed through the per diem rate, revenue for Medicaid therapy services, Medicaid non-routine medical supplies, and Medicaid Parenteral and Enteral Nutrition (PEN) items should be reported on Line 231, 232, 233, 234, 236, and 239 using gross charges consistently applied to all payer types. The total amount of the Medicaid therapy, non-routine medical supply, and Parenteral and Enteral Nutrition (PEN) should then be netted to zero with a contractual adjustment on Line 263 (Less Contractual/Charity Allowances)." The instructions make no mention of inputting revenue for Medicare therapy services.

The reason Houston reported Medicare Part B therapy revenue is because Part B therapy is separately billable and isn't included in the PPS Part A per diem rate. Houston received revenue for these Part B therapy services, the revenue was clearly identifiable to the therapy service, the revenue wasn't routine income and per the cost report instructions must be reported.

UNALLOWABLE COSTS

Legal fees

Houston disagrees with the legal fees adjustment. 48 CFR § 31.205-47(b) is a Federal Acquisition Regulation applicable to "contractors" like defense contractors, etc. who were selected using the government procurement process. This regulation does not apply to Medicaid providers. The administrative review of survey findings is not a civil proceeding.

Houston **did not** report $51,717 in unallowable legal fees on the Ben Hur 2005 Cost report. Houston removed $58,310 in legal fees on its filed 2005 Medicaid Cost report Provider Adjustment Col (24), Line 9 (Exhibit 4). The OIG audit determined that figure should have been $51,717. Consequently, Houston under reported legal fees by $6,593 on its filed 2005 Medicaid Cost Report.

Unsupported Real Estate and Property Taxes

Houston will not dispute the Real Estate and Property taxes adjustment. This error occurred due to delays in receiving our Real and Property tax statements. We based our Real Estate and Property tax expense on prior year statements and received the current year's statements after the companies' year ends. We did adjust Real Estate and Property tax expense in subsequent years to correct the over reporting in 2005.

Office and Building Equipment Not Capitalized

Houston will not dispute the Office and Building Equipment Not Capitalized adjustments but recommends it be removed from Table 2 and that Table 3 be reported under Misclassified Reported Costs and Unreported Costs on page 10 of the draft audit report.

Vehicle Accident Costs *

Houston did take prudent action in reducing its total Medicaid costs. The two accidents were paid by Houston Group Homes and were not submitted to our insurance carrier based on Houston's knowledge and history of the insurance industry. Houston would have been responsible to pay the deductible on both of these claims, which we believe was $500/claim. Had Houston submitted these accidents to our carrier, we would have initially saved $9 on the Penn Hall accident and $1,078 on the Pine Ridge accident. However, insurance companies offer discounts for accident free renewals so submitting these two minor claims would have cost us more in the long run with increased premiums in future years. Insurance companies consider frequency of claims more than they consider dollar amount of claims when determining their premium charge. Insurance companies request three years of claims history prior to submitting any proposal. Consequently, companies receive very favorable premium rates when claims histories show no claims.

COSTS NOT ALLOCABLE AND RELATED TO PATIENT CARE

Personal Mortgage Interest and Insurance for Owner's Personal Rental Properties

On page 7, last paragraph, second sentence, it reads "These costs included personal mortgage interest". This is incorrect; there was no personal mortgage interest paid by any Houston company nor was there any personal mortgage interest reported on any Medicaid Cost Report. On page 8, the sentence "Personal Mortgage Interest and Insurance for Owner's Personal Rental Properties" is incorrect. The next sentence which

*Office of Inspector General Note—Technical comments in the auditee's response to the draft have been omitted from the final report and all appropriate changes have been made.

reads in part "for the owner's personal and rental properties" is incorrect. The next sentence which reads "Table 5: Personal Mortgage Interest and Insurance Costs Not Allocable" is incorrect. Again, the Owner's did not report any personal mortgage interest or insurance for personal rental properties. In fact, the owner's do not own any rental properties.

The rental properties are residential houses that border Ben Hur and are owned by Ben Hur and are rented to employees and non-employees as single family residences. The personal property are 2 leased vehicles and construction equipment owned by Houston that was used during the construction of Williamsburg, Ben Hur expansions and other nursing home expansions previously owned by Houston.

It should be noted that the reporting of the $8,588 in Mortgage interest on the Ben Hur Cost report had no effect in the Medicaid calculated rate. Myers and Stauffer remove all Mortgage interest in calculating the Capital Per Patient Day Costs which is used to calculate the Capital Component of the Medicaid Rate. The inclusion of this Mortgage interest did not increase the Medicaid rate. I have attached the fiscal years' 2003-2005 calculation worksheets from Ben Hur's Notice of New or Adjusted Medicaid Rate which verifies this (Exhibit 5-7).

Non-Medicaid-Related Facilities

Houston will not dispute the Raw Food, Bonus, and Repair adjustments. These were isolated clerical errors illustrated by the fact they didn't occur in all 3 years.

Village Drug Store **

Houston disagrees with the Village Drug Store Utilities adjustments for 2003 and 2005. Houston recommends ½ of the adjustments for 2003 and 2005 be removed from Table 4 and reported under Misclassified Reported Costs and Unreported Costs on page 10 of the draft audit report and allocated to the group home cost reports for 2003 and 2005. Houston will not dispute the Village Drug Store utility expense adjustment for 2004. Village Drug Store rents ½ of an office building owned by Ben Hur and Group Homes rents the other ½. Per the lease, Ben Hur paid for the utilities. Houston failed to remove the drug store share of utilities in its preparation of the cost reports. The lease has been amended so that the drug store and group homes pay their utilities directly.

Owner's Personal Vehicle

Regarding the Owner's Personal Vehicle, the vehicle was leased in the owner's name due to credit approval processing. Since Ben Hur is an S-Corp owned by one individual, the leasing company either wanted a personal guarantee from the owner if leased by Ben Hur or wanted the owner to lease directly.

The Cost Report instructions, page 9 states Owner's Expenses are to be reported on Lines 405 and 416 of the cost report. The instructions specifically list Automobile under #2

**Office of Inspector General Note—Technical comments in the auditee's response to the draft have been omitted from the final report and all appropriate changes have been made.

(Exhibit 8). Houston correctly reported the Owner's automobile on Line 405 of the 2004 cost report. Houston did remove $4,815 from Line 405 on its filed 2004 Medicaid Cost Report Provider Adjustments Col (24), line 31 (Exhibit 9). Consequently, only $1,766 of Automobile lease payments was reported on the 2004 Medicaid Cost Report Schedule E, column 4.

Non-Operational Facility

Houston will not dispute the Non-Operational Facility adjustments. The expenses for this closed facility are coded to non-patient related accounts and are removed from the Cost reports via the Provider Adjustments Col (24) worksheet. These bills were miscoded by Accounts Payable and consequently were not removed.

Vehicles Not Used for Patient Care

Houston will not dispute the vehicle costs adjustments. The license plates were for the property listed above in paragraph 2. Houston disagrees with the traffic ticket adjustment. The ticket was issued by the Indiana State Police Commercial Vehicle Enforcement division for the laundry truck which is used to deliver laundry to Williamsburg and is certainly patient related. The ticket was for not displaying correct signage on the outside, unsecured fire extinguisher, horn inoperative, no battery box cover, seat belt violation, and other various infractions. The OIG position that traffic tickets are not allowable is not supported by any authority.

Employee Overtime and Materials Not Related to Patient Care

Houston disagrees the hours were not associated with patient care. Houston utilizes the Kronos time card system and overtime is figured automatically by the Kronos software. Consequently, Houston is perplexed as to why most of Houston's overtime is accurate except for $2,761.

MISCLASSIFIED REPORTED COSTS AND UNREPORTED COSTS

Other than recommending the Office and Building Equipment Not Capitalized adjustments and ½ of the Village Drug Store Utilities adjustments be reported under Misclassified Reported Costs and Unreported Costs on page 10 of the draft audit report, Houston will not dispute the clerical errors adjustments.

POTENTIALLY UNALLOWABLE RELATED-PARTY TRANSACTIONS

Oxygen Purchases

Houston disagrees with the OIG opinion that Village Drug Store does not meet the related party exception. 405 IAC 1-14.6-11e allows the State to grant a related party exception if four conditions are met (Exhibit 10-11). For the past several years, the State

has determined Houston meets the four conditions and has granted Houston a related party exception.

When Village provides prescriptions to non-Medicare residents of the Houston facilities, its business activity is transacted with other than the provider and organizations related to the supplier in common ownership or control. Village is supplying prescriptions to the residents, not to the facilities. The residents do not have to do business with Village, they are allowed to choose any pharmacy to provide their prescriptions (in fact, some do utilize other pharmacies). Village does not bill the related party facilities for the prescriptions they supply to non-Medicare residents; it bills Medicare Part D, Medicaid, other insurance, and the residents themselves. Consequently, a sufficient part of the supplying organization's business activity is transacted with other than the provider and organizations related to the supplier in common ownership or control.

Village is not the only pharmacy in Crawfordsville. There are several pharmacies serving Crawfordsville; CVS, Walgreens, Wal-Mart and Kroger. Clearly, there is an open competitive market for the supplies furnished by Village.

Village owns all the oxygen tanks utilized to deliver the oxygen to the residents and the OIG didn't consider the tanks' cost when they determined Village's cost. The OIG didn't consider Village's overhead in the oxygen cost. The OIG only used the actual oxygen cost from Village's vendor.

Upon the receipt of the final audit from the OIG, Houston will contact Myers and Stauffer to determine whether it will be necessary to submit revised cost reports. Should amended cost reports be required, Houston:

- will not report Medicare Part A revenues totaling $1.5 Million,
- will reduce costs by $56,560 that were not allowable and allocable,
- will reclassify $23,797 and report $18,758 in allowable costs,
- will continue to submit its related party request to the State every two years, and
- will revise its internal controls and procedures as needed.

Sincerely,

Daniel Houston, President
Houston Companies, Inc.

Enclosures

has determined Houston meets the four conditions and has granted Houston a related party exception.

When Village provides prescriptions to non-Medicare residents of the Houston facilities, its business activity is transacted with other than the provider and organizations related to the supplier in common ownership or control. Village is supplying prescriptions to the residents, not to the facilities. The residents do not have to do business with Village, they are allowed to choose any pharmacy to provide their prescriptions (in fact, some do utilize other pharmacies). Village does not bill the related party facilities for the prescriptions they supply to non-Medicare residents; it bills Medicare Part D, Medicaid, other insurance, and the residents themselves. Consequently, a sufficient part of the supplying organization's business activity is transacted with other than the provider and organizations related to the supplier in common ownership or control.

Village is not the only pharmacy in Crawfordsville. There are several pharmacies serving Crawfordsville; CVS, Walgreens, Wal-Mart and Kroger. Clearly, there is an open competitive market for the supplies furnished by Village.

Village owns all the oxygen tanks utilized to deliver the oxygen to the residents and the OIG didn't consider the tanks' cost when they determined Village's cost. The OIG didn't consider Village's overhead in the oxygen cost. The OIG only used the actual oxygen cost from Village's vendor.

Upon the receipt of the final audit from the OIG, Houston will contact Myers and Stauffer to determine whether it will be necessary to submit revised cost reports. Should amended cost reports be required, Houston:

- will not report Medicare Part A revenues totaling $1.5 Million,
- will reduce costs by $56,560 that were not allowable and allocable,
- will reclassify $23,797 and report $18,758 in allowable costs,
- will continue to submit its related party request to the State every two years, and
- will revise its internal controls and procedures as needed.

Sincerely,

Daniel Houston, President
Houston Companies, Inc.

Enclosures

EXHIBIT 1

IC 12-15-14
Chapter 14. Payment to Nursing Facilities

IC 12-15-14-1
Payment criteria; uniformity

Sec. 1. (a) Except as provided in subsection (b), payment of services for nursing facilities shall be determined under the same criteria and in a uniform manner for all facilities providing services.

(b) In addition to reimbursement under the uniform rates of payment developed for all nursing facilities under subsection (a):

(1) nursing facilities that are owned and operated by a governmental entity may receive any additional payments that are permitted under applicable federal statutes and regulations; and

(2) nursing facilities that are not owned and operated by a governmental entity may receive any additional payments that are permitted under applicable federal statutes and regulations.

(c) Each governmental transfer or other payment mechanism that the office implements under this chapter must maximize the amount of federal financial participation that the state can obtain through the intergovernmental transfer or other payment mechanism.

As added by P.L.2-1992, SEC.9. Amended by P.L.160-2001, SEC.1.

IC 12-15-14-2
Payment of nursing facilities under 42 U.S.C. 1396a(a)(13)(A); non-Medicaid revenue information; complete balance sheet data

Sec. 2. (a) Payment of nursing facility services shall be determined in accordance with 42 U.S.C. 1396a(a)(13)(A) and any other applicable federal statutes or regulations governing such payments.

(b) The office may not require a provider to submit non-Medicaid revenue information in the provider's annual historical financial report. Non-Medicaid revenue information obtained by Medicaid auditors in the course of their audits may not be used for public reporting purposes.

(c) The office may only request complete balance sheet data that applies directly to the provider's facility. Complete balance sheet data acquired by the office under this subsection:

(1) is confidential; and

(2) may only be disclosed:

(A) in the aggregate; or

(B) for an individual facility;

if the office removes all non-Medicaid data.

(d) The office of the secretary shall adopt rules under IC 4-22-2 to implement the reimbursement system required by this section.

As added by P.L.2-1992, SEC.9. Amended by P.L.152-1995, SEC.11; P.L.257-1996, SEC.10; P.L.126-1998, SEC.3; P.L.160-2001, SEC.2.

IC 12-15-14-3
Repealed

EXHIBIT 2

provider to report federal income taxes for the operation unless the provider requests in writing that a different reporting period be used. Such a request shall be submitted within sixty (60) days after the initial certification of a provider. This option may be exercised only one (1) time by a provider and must coincide with the fiscal year end for Medicare cost reporting purposes. If a reporting period other than the tax year is established, audit trails between the periods are required, including reconciliation statements between the provider's records and the annual financial report. Nursing facilities that are certified to provide Medicare-covered skilled nursing facility services are required to submit a written and electronic cost report (ECR) file copy of their Medicare cost report that covers their most recently completed historical reporting period. Nursing facilities that have been granted an exemption to the Medicare filing requirement to submit the ECR file by the Medicare fiscal intermediary shall not be required to submit the ECR file to the office.

(b) The first annual Financial Report for Nursing Facilities for a provider that has undergone a change of provider ownership or control through an arm's-length transaction between unrelated parties shall coincide with that provider's first fiscal year end in which the provider has a minimum of six (6) full calendar months of actual historical financial data. The provider shall submit their first annual financial report to the office not later than the last day of the fifth (5th) calendar month after the close of the provider's reporting year or thirty (30) days following notification that the change of provider ownership has been reviewed by the office or its contractor. Nursing facilities that are certified to provide Medicare-covered skilled nursing facility services are required to submit a written and electronic ECR file copy of their Medicare cost report that covers their most recently completed historical reporting period.

(c) The provider's annual financial report shall be submitted using forms prescribed by the office. All data elements and required attachments shall be completed so as to provide full financial disclosure and shall include the following as a minimum:

(1) Patient census data.

(2) Statistical data.

(3) Ownership and related party information.

(4) Statement of all expenses and all income, excluding non-Medicaid routine income.

(5) Detail of fixed assets and patient-related interest bearing debt.

(6) Complete balance sheet data.

(7) Schedule of Medicaid and private pay charges in effect on the last day of the reporting period. Private pay charges shall be the lowest usual and ordinary charge.

(8) Certification by the provider that:

(A) the data are true, accurate, related to patient care; and

(B) expenses not related to patient care have been clearly identified.

(9) Certification by the preparer, if different from the provider, that the data were compiled from all information provided to the preparer by the provider and as such are true and accurate to the best of the preparer's knowledge.

(10) Copy of the working trial balance that was used in the preparation of their submitted Medicare cost report.

(d) Extension of the five (5) month filing period shall not be granted.

(e) Failure to submit an annual financial report or Medicare cost report by nursing facilities that are certified to provide Medicare-covered skilled nursing facility services within the time limit required shall result in the following actions:

(1) No rate review shall be accepted or acted upon by the office until the delinquent reports are received.

(2) When an annual financial report or Medicare cost report by nursing facilities that are certified to provide Medicare-covered skilled nursing facility services is more than one (1) calendar month past due, the rate then currently being paid to the provider shall be reduced by ten percent (10%), effective on the first day of the seventh (7th) month following the provider's fiscal year end and shall so remain until the first day of the month after the delinquent annual financial report or Medicare cost report (if required) is received by the office. No rate adjustments will be allowed until the first day of the calendar quarter following receipt of the delinquent annual financial report. Reimbursement lost because of the penalty cannot be recovered by the provider. If the Medicare filing deadline for submitting the Medicare cost report is delayed by the Medicare fiscal intermediary, and the provider fails to submit their Medicare cost report to the office on or before the due date as extended by the Medicare fiscal intermediary, then the ten percent (10%) rate reduction for untimely filing to the office as referenced herein shall become effective on the first day of the month following the due date as extended by the Medicare fiscal intermediary.

(f) Nursing facilities are required to electronically transmit MDS resident assessment information in a complete, accurate, and timely manner. MDS resident assessment information for a calendar quarter must be transmitted by the fifteenth day of the second month following the end of that calendar quarter. Extension of the electronic MDS assessment transmission due date may be granted by the office to a new operation attempting to submit MDS assessments for the first time if the new operation is not currently enrolled

EXHIBIT 3

Schedule C -- Schedule of Charges

Schedule C should be completed on all financial reports submitted. Column [01] should reflect the lowest usual and ordinary charge for private pay residents for like levels of services in effect at the report year end (RYE). Providers should complete Column [01] on all applicable room configuration lines.

Schedule D -- Schedule of Revenue

Schedule D should disclose all revenues from the facility's operation, and should reconcile to the provider's financial records, including the working trial balance. Routine and ancillary revenues from all payer sources should be reported on the appropriate lines and columns. Income that should be offset against a related expense must also be reported, and question [26810] should be answered at the bottom of Schedule D. Submit a schedule detailing the Schedule E line number(s) against which these revenues should be or have been offset.

The revenues reported in Column [06] (Total) should be allocated between Columns [07] (Nursing Facility) and [08] (Other) based upon the gross amount charged to each resident classification. For example, if an assisted living resident generates gross charges for routine daily service, the associates revenues should be reported in Column [08] (Other.)

Line 211 -- Routine Daily Service Routine daily service revenue should be reported in the appropriate columns as gross revenue by the primary payer source (i.e., if the primary payor is Medicare and the Medicaid program pays for co-insurance, then the gross routine service revenue should be reported in the Medicare column).

Lines 231, 232, 233, 234, 236 and 239 -- Physical Therapy, Speech and Audiology Therapy, Occupational Therapy, Respiratory Therapy, Sale of Non-Routine Medical Supplies and Parenteral and Enteral Nutrition (PEN) Therapy revenue, non-routine medical supply revenue, and Parenteral and Enteral Nutrition (PEN) should be reported in the appropriate column by actual payment source (i.e., Medicaid, Medicare Part A and Part B, Private Pay or Other). Although the criteria requires therapy, non-routine medical supply items, and Parenteral and Enteral Nutrition (PEN) items to be reimbursed through the per diem rate, revenue for Medicaid therapy services, Medicaid non-routine medical supplies, and Medicaid Parenteral and Enteral Nutrition (PEN) items should be reported in Column [01] using gross charges consistently applied to all payer types. The total amount of the Medicaid therapy, non-routine medical supply, and Parenteral and Enteral Nutrition (PEN) should then be netted to zero with a contractual adjustment on Line 263 (Less Contractual/Charity Allowances).

Lines 241, 242, 243, 244, 245, 246 and 247 - Florist, Barber/Beauty Shop, Vending Machines, Personal Purchases, Meals Sold to Guest and Employees, Activity Sales, Investment Income - Interest & Dividends Total revenue for these lines must be reported, however the total revenue may be combined and reported in column [05] Other.

EXHIBIT 4

DHE '05
PROVIDER ADJUSTMENT Col [24]
Provider adjustments consists of allocations from the home office and adjustments to expenses. The following adjustments to accounts are made, the subsequent worksheets summarizes these and the home office allocations.

Description	Line	Hours	Amount
1. Remove Contributions #9590	398		(25)
2. Remove Promotional Advert. #8802 & #8804	392		(4,765)
3. Offset Interest Expense with Interest Income	401		(15)
4. Offset HDI Laundry Costs #8160	341	(7,587)	(70,512)
5. Remove Vending #8070	457		(74)
6. Remove Non-Pat Related Owner Exp #9018	405		(7,768)
7. Remove Non-Pat Related R&M #9630	353		0
8. Remove Houston Co. Service Fees #8660	406		(177,885)
9. Remove Legal Fees	391		(58,310)
10. Non-Patient Related Meals #9178	394		(204)
11. Offset Garnishment Revenue #4991	407		(610)
12. Offset Pharmacy Service #4865	316		(655)
13. Offset Day Care Rev. #4350 to Aides	314		0
14. Remove R/E Tax Grant & Ardmore #8441	373		(6,145)
15. Remove Non-Ded. IHCA/AHCA/HOPE Dues	396		(160)
16. Remove Non-Pat Related Apts R&M #8371	353		(3,671)
17. Remove Non-Pat Related Apt Utilities #8561	352		0
18. Remove Non-Pat Related Travel #9177	394		0
19. Remove Tax Penalties	407		0
20. Remove G/A - Apartments #9791	407		0
21. Remove Grant & Ardmore Depreciation	362		(5,206)
22. Remove Houston Unit Expenses			
Plant Operations: Contracted	353		(1,356)
Utilities	352		(14,843)
Mortgage Interest	361		(27,060)
Real Estate Tax	373		(9,915)
Salaries-Plant Operation	351		(13)
Plant Operations-Supplies	357		(30)
Repair-Building	353		(434)
Depreciation-Building	362		(47,141)
Depreciation-Equipment	363		(6,262)
23. Remove Owner's Vehicle Exp-Depreciation	363		(10,271)
24. Remove Owner's Vehicle Exp-Interest	361		(1,685)
25. Offset Misc. Inc. for Misc. Office Supplies	397		0
26. Offset Misc. Income for Medicare interest	401		0
27. Offset Misc. Income for Employee Education	407		(500)
28. Offset Misc. Income for Patronage Dividend	318		(726)
29. Offset Misc. Income for Employee Testing	407		(112)
		(7,587)	(456,354)

EXHIBIT 5

Provider Name: BEN HUR HOME, INC.
Report Year End: 12/31/2003

AIM Number: 100275290

COST PROFILE

Schedule of Expenses: 01/01/2003 through 12/31/2003

Line No.	Description	Reported Expense	Rate Setter Adjustments	Inflated Adjusted Expense	Alloc Basis	Per Diem
	CAPITAL PER PATIENT DAY COSTS					
	OTHER CAPITAL					
361	Facility Interest	193,816	(193,816)	0	0	0.00
362	Depreciation - Building	107,083	(107,083)	0	0	0.00
363	Depreciation - Equipment	51,657	(51,657)	0	0	0.00
364	Lease - Building	2,517	(2,517)	0	0	0.00
365	Lease - Equipment	5,801	(5,801)	0	0	0.00
371	Insurance	15,744		16,182	0	0.39
372	Repairs & Maintenance	134,206		137,937	0	3.30
373	Real Estate Taxes	22,144		22,760	0	0.54
374	Personal Property Taxes	1,053		1,082	0	0.03
377	Other Capital Costs	0		0	0	0.00
378	Total Other Capital Costs	534,021	(360,874)	177,961		4.26
	Less Repairs and Maintenance	(134,206)	0	(137,937)		-3.30
	Total Other Capital Costs Less Repairs and Maintenance	399,815	(360,874)	40,024		0.96
	Fair Rental Value Allowance			504,008		
	Allowable Capital Costs			544,032		
	Actual Patient Days or 95% Minimum Occupancy			45,771		
	Capital Per Patient Day Costs			11.89		

EXHIBIT 6

Provider Name: BEN HUR HOME, INC. **Report Year End:** 12/31/2004

AIM Number: 100275290

COST PROFILE

Schedule of Expenses: 01/01/2004 through 12/31/2004

Line No.	Description	Reported Expense	Rate Setter Adjustments	Inflated Adjusted Expense	Alloc Basis	Per Diem
CAPITAL PER PATIENT DAY COSTS						
	OTHER CAPITAL					
361	Facility Interest	175,064	(175,064)	0	0	0.00
362	Depreciation - Building	107,537	(107,537)	0	0	0.00
363	Depreciation - Equipment	55,188	(55,188)	0	0	0.00
364	Lease - Building	2,538	(2,538)	0	0	0.00
365	Lease - Equipment	5,831	(5,831)	0	0	0.00
371	Insurance	14,127		14,649	0	0.35
372	Repairs & Maintenance	150,239		155,788	0	3.77
373	Real Estate Taxes	11,792		12,228	0	0.30
374	Personal Property Taxes	3,759		3,898	0	0.09
377	Other Capital Costs	0		0	0	0.00
378	Total Other Capital Costs	526,075	(346,158)	186,563		4.52
	Less Repairs and Maintenance	(150,239)	0	(155,788)		-3.77
	Total Other Capital Costs Less Repairs and Maintenance	375,836	(346,158)	30,775		0.75
	Fair Rental Value Allowance			562,816		
	Allowable Capital Costs			593,591		
	Actual Patient Days or 95% Minimum Occupancy			45,896		
	Capital Per Patient Day Costs			12.93		

EXHIBIT 7

Provider Name: BEN HUR HOME, INC. **Report Year End:** 12/31/2005

AIM Number: 100275290

COST PROFILE

Schedule of Expenses: 01/01/2005 through 12/31/2005

Line No.	Description	Reported Expense	Rate Setter Adjustments	Inflated Adjusted Expense	Alloc Basis	Per Diem
CAPITAL PER PATIENT DAY COSTS						
	OTHER CAPITAL					
361	Facility Interest	153,423	(153,423)	0	0	0.00
362	Depreciation - Building	107,565	(107,565)	0	0	0.00
363	Depreciation - Equipment	44,702	(44,702)	0	0	0.00
364	Lease - Building	2,321	(2,321)	0	0	0.00
365	Lease - Equipment	5,664	(5,664)	0	0	0.00
371	Insurance	8,852		9,172	0	0.26
373	Real Estate Taxes	29,070		30,120	0	0.85
374	Personal Property Taxes	8,150		8,444	0	0.24
377	Other Capital Costs	0		0	0	0.00
378	Total Other Capital Costs	359,747	(313,675)	47,736		1.34

Fair Rental Value Allowance	542,504
Allowable Capital Costs	590,240
Actual Patient Days or 95% Minimum Occupancy	41,610
Capital Per Patient Day Costs	14.19

government, these costs should be identified by Schedule E line and column number as an attachment to the financial report. In accordance with 405 IAC 1-4.3, these costs shall not be reimbursed as reasonably related medical expenses, and should be removed by the provider in Column [24].

Lines 392 and 393 -- Advertising All advertising costs, except for help wanted advertising, should be reported on Line 392 (Advertising - All Other). Reasonable help wanted advertising is an allowable cost and should be reported on Line 393 (Advertising - Help Wanted). In accordance with 405 IAC 1-14.6-8(a), except for those advertising costs incurred in the recruitment of facility personnel necessary for compliance with facility certification requirements, advertising costs are not allowable costs and should be eliminated by the provider in Column [24] of Line 392.

Line 394 -- Travel Report on Line 394 (Travel Expenses) only the reasonable patient-related travel costs of personnel that are not owners. Owner travel that is reasonable and patient-related should be reported on line 405 (Owner's Expense).

Lines 405 and 416 -- Owner's Expenses Report on these two lines the cost of owner's expenses. Generally, the cost of discriminatory employee benefits for owners should be reported on line 416 (Owners' Benefits) and all other owner's expenses reported on Line 405 (Owners' Expense). Discriminatory employee benefits are those that tend to benefit owners proportionately more than other personnel. The entire cost of the following items that relate to owners should be reported on the applicable Line 405 or 416:

1. Travel, entertainment and continuing education
2. Automobile, aircraft, travel and transportation allowances and related costs
3. Employee benefits except benefits available to all employees on a nondiscriminatory basis
4. Cost of life insurance above the amount causing an employee to recognize taxable income
5. Employee benefits or expense reimbursements that cause an employee to recognize taxable income

Line 406 -- Consultant Fees In order for an item to be reported on this line, the consultant shall not be included in the definition of owner, related party, management or consultant at 405 IAC 1-14.6-18(a). Line 406 (Consultant Fees) is intended for reporting the cost of independent contractors that are not parties related to the facility, that provide general and administrative services related to patient care that are not normally provided in-house by employees of the facility, and where the consultant and consultant's employees lack the ability to implement. No other expense items should be reported on this line. The costs of management agreements should not be reported on Line 406, but should be reported on Line 383. A detailed listing of consultant fees must be reported in Schedule H -- Consultant Fees.

Lines 411, 412, 413, 414, 415 and 417 -- Employee Benefits Employee benefits should be reported on the line that is most descriptive of the benefit provided. Only benefits that are available to all employees on a nondiscriminatory basis should be reported on Lines 411 (Payroll Taxes), 412 (Health Insurance), 413 (Life Insurance - Not in Excess of Limits), 414 (Workers' Compensation), 415 (Qualifying Pensions) and 417 (Other Qualifying Benefits). Discriminatory benefits should be reported on Line 416 (Owners' Benefits).

EXHIBIT 9

DHE '04
PROVIDER ADJUSTMENT Col [24]
Provider adjustments consists of allocations from the home office and adjustments to expenses. The following adjustments to accounts are made, the subsequent worksheets summarizes these and the home office allocations.

Description	Line	Hours	Amount
1. Remove Contributions #9590	398		(227)
2. Remove Promotional Advert. #8802 & #8804	392		(7,438)
3. Offset Interest Expense with Interest Income	401		(72)
5. Offset Vending Sales to Expense #4870	333		(916)
6. Remove Non-Pat Related Owner Exp #9018	405		(2,067)
7. Remove Non-Pat Related R&M #9630	372		0
8. Remove Houston Co. Service Fees #8660	406		(261,338)
10. Offset Food Sales to Food Expense #4750	333		(12)
11. Non-Patient Related Meals #9178	394		(20)
12. Offset Garnishment Revenue #4991	407		(417)
13. Offset Pharmacy Service #4865	316		(1,390)
14. Offset Day Care Rev. #4350 to Aides	314		(38)
15. Offset Personal Purchases Income #4860	318		(1,280)
18. Remove R/E Tax Grant & Ardmore #8441	373		(4,516)
19. Remove Nonded. IHCA/AHCA/HOPE Dues	396		(554)
20. Remove Non-Pat Related Apts R&M #8371	372		(330)
21. Remove Non-Pat Related Apt Utilities #8561	352		(128)
23. Remove Non-Pat Related Travel #9177	394		0
24. Remove Tax Penalties	407		(1)
26. Remove G/A - Apartments #9791	407		(17)
27. Remove Grant & Ardmore Depreciation	362		(5,221)
30. Remove Houston Unit Expenses			
Plant Operations: Contracted	372		(554)
Utilities	352		(12,988)
Mortgage Interest	361		(30,299)
Real Estate Tax	373		(8,766)
Depreciation-Building	362		(47,270)
Depreciation-Equipment	363		(6,280)
31. Remove Owner's Vehicle Exp-Interest & Depr.	405		(4,815)
32. Offset Misc. Inc. for Misc. Office Supplies	397		(49)
33. Offset Misc. Income for Medicare interest	401		0
34. Offset Misc. Income Employee Mantoux	407		(4)
35. Offset Misc. Income for Patronage Dividend	318		(501)
36. Offset Misc. Income for Employee Testing	407		(120)
37. Offset HDI Laundry Costs #8160	341	(8,702)	(71,634)
TOTAL ADJUSTMENTS		(8,702)	(469,261)

EXHIBIT 10

Percentage	100%	80%

(5) For the therapy component, no overall rate component limit shall apply.

(d) In order to determine the normalized allowable direct care costs from each facility's Financial Report for Nursing Facilities, the office or its contractor shall determine each facility's CMI for all residents on a time-weighted basis.

(e) The office shall publish guidelines for use in determining the time-weighted CMI. These guidelines:

(1) shall be published as a provider bulletin; and

(2) may be updated by the office as needed.

Any such updates shall be made effective no earlier than permitted under IC 12-15-13-6(a). *(Office of the Secretary of Family and Social Services; 405 IAC 1-14.6-9; filed Aug 12, 1998, 2:27 p.m.: 22 IR 75, eff Oct 1, 1998; filed Mar 2, 1999, 4:42 p.m.: 22 IR 2244; readopted filed Jun 27, 2001, 9:40 a.m.:24 IR 3822; filed Mar 18, 2002, 3:30 p.m.: 25 IR 2470; filed Oct 10, 2002, 10:47 a.m.: 26 IR 714; filed Jul 29, 2003, 4:00 p.m.: 26 IR 3874; filed Apr 24, 2006, 3:30 p.m.: 29 IR 2980)*

405 IAC 1-14.6-10 Computation of rate; allowable costs; review of cost reasonableness

Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-21-2
Affected: IC 12-13-7-3; IC 12-15

Sec. 10. (a) Costs and revenues, excluding non-Medicaid routine revenue, shall be reported as required on the financial report forms. Allowable patient care costs shall be clearly identified.

(b) The provider shall report as patient care costs only costs that have been incurred in the providing of patient care services. The provider shall certify on all financial reports that costs not related to patient care have been separately identified on the financial report.

(c) In determining reasonableness of costs, the office may compare line items, cost centers, or total costs of providers throughout the state. The office or its contractors may request satisfactory documentation from providers whose costs do not appear to be accurate or allowable.

(d) Indiana state taxes, including local taxes, shall be considered an allowable cost. Personal or federal income taxes are not considered allowable costs. *(Office of the Secretary of Family and Social Services; 405 IAC 1-14.6-10; filed Aug 12, 1998, 2:27 p.m.: 22 IR 76, eff Oct 1, 1998; filed Mar 2, 1999, 4:42 p.m.: 22 IR 2245; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822)*

405 IAC 1-14.6-11 Allowable costs; services provided by parties related to the provider

Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-21-2
Affected: IC 12-13-7-3; IC 12-15

Sec. 11. (a) Costs applicable to services, facilities, and supplies furnished to the provider by organizations related to the provider by common ownership or control may be included in the allowable cost in the unit of service of the provider at the cost to the related organization. However, such cost must not exceed the price of comparable services, facilities, or supplies that could be purchased elsewhere in an arm's-length transaction.

(b) Common ownership exists when an individual, individuals, or any legal entity possesses ownership or equity of at least five percent (5%) in the provider as well as the institution or organization serving the provider. An individual is considered to own the interest of immediate family for the determination of percentage of ownership. The following persons are considered immediate family:

(1) Husband and wife.

(2) Natural parent, child, and sibling.

(3) Adopted child and adoptive parent.

(4) Stepparent, stepchild, stepsister, and stepbrother.

(5) Father-in-law, mother-in-law, sister-in-law, brother-in-law, son-in-law, and daughter-in-law.

(6) Grandparent and grandchild.

(c) Control exists where an individual or an organization has the power, directly or indirectly, to influence or direct the actions or policies of an organization or institution, whether or not actually exercised. A general partner is considered to control an entity.

(d) Transactions between related parties are not considered to have arisen through arm's-length negotiations. Costs applicable to services, facilities, and supplies furnished to a provider by related parties shall not exceed the lower of the cost to the related party, or the price of comparable services, facilities, or supplies purchased elsewhere. An exception to this subsection may be granted by

EXHIBIT 11

the office if requested in writing by the provider before the annual rate review effective date to which the exception is to apply. The provider's request shall include a comprehensive representation that every condition in subsection (e) has been met. This representation shall include, but not be limited to, the percentage of business the provider transacts with related and nonrelated parties based upon revenue. When requested by the office, documentation to substantiate the provider's charges for services, facilities, or supplies to related and nonrelated parties, such as invoices, standard charge master listings, and remittances, must be submitted.

(e) The office shall grant an exception when a related organization meets all of the following conditions:

(1) The supplying organization is a bona fide separate organization.

(2) A sufficient part of the supplying organization's business activity is transacted with other than the provider and organizations related to the supplier in common ownership or control, and there is an open competitive market for the type of services, facilities, or supplies furnished by the organization.

(3) The services, supplies, or facilities are those that commonly are obtained by institutions, such as the provider, from other organizations and are not a basic element of patient care ordinarily furnished directly to patients by such institutions.

(4) The charge to the provider is in line with the charge for such services, facilities, or supplies in the open market and no more than the charge made under comparable circumstances to others by the organization for such services, facilities, or supplies.

(Office of the Secretary of Family and Social Services; 405 IAC 1-14.6-11; filed Aug 12, 1998, 2:27 p.m.: 22 IR 76, eff Oct 1, 1998; filed Mar 2, 1999, 4:42 p.m.: 22 IR 2245; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822)

405 IAC 1-14.6-12 Allowable costs; fair rental value allowance

Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-21-2
Affected: IC 12-13-7-3; IC 12-15

Sec. 12. Providers shall be reimbursed for the use of allowable patient-related facilities and equipment, regardless of whether they are owned or leased, by means of a fair rental value allowance. The fair rental value allowance shall be in lieu of the costs of all depreciation, interest, lease, rent, or other consideration paid for the use of property. This includes all central office facilities and equipment whose patient care-related depreciation, interest, or lease expense is appropriately allocated to the facility.

(1) The fair rental value allowance is calculated by determining, on a per bed basis, the historical cost of allowable patient-related property for facilities that are not acquired through an operating lease arrangement, including:

(A) land, building, improvements, vehicles, and equipment; and

(B) costs;

required to be capitalized in accordance with generally accepted accounting principles. Land, buildings, and improvements shall be adjusted for changes in valuation by inflating the reported allowable patient-related historical cost of property from the later of July 1, 1976, or the date of facility acquisition to the present based on the change in the R. S. Means Construction Index.

(2) The inflation-adjusted historical cost of property per bed as determined above is arrayed to arrive at the average historical cost of property of the median bed.

(3) The average historical cost of property of the median bed as determined above is extended times the number of beds for each facility that are used to provide nursing facility services to arrive at the fair rental value amount.

(4) The fair rental value amount is extended by a rental rate to arrive at the fair rental allowance. The rental rate shall be a simple average of the United States Treasury bond, ten (10) year amortization, constant maturity rate plus three percent (3%), in effect on the first day of the month that the index is published for each of the twelve (12) months immediately preceding the rate effective date as determined in section 6(a) of this rule. The rental rate shall be updated quarterly on January 1, April 1, July 1, and October 1.

(Office of the Secretary of Family and Social Services; 405 IAC 1-14.6-12; filed Aug 12, 1998, 2:27 p.m.: 22 IR 77, eff Oct 1, 1998; filed Sep 1, 2000, 2:10 p.m.: 24 IR 21; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Oct 10, 2002, 10:47 a.m.: 26 IR 715)

405 IAC 1-14.6-13 Reporting of financing arrangements; working capital; interest; allocation of loans

Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-21-2
Affected: IC 12-13-7-3; IC 12-15

Sec. 13. (a) All patient-related property financing arrangements shall be fully and completely disclosed on the forms prescribed