

**STATE OF NEW YORK
DEPARTMENT OF HEALTH**

In the Matter of the Appeal of :
: **Decision After**
ODD FELLOW & REBEKAH : **Hearing**
REHABILITATION AND HEALTH :
CARE CENTER, INC. :
Medicaid Provider # [REDACTED] :
: #06-7527
from a determination to recover Medicaid Program :
overpayments :
:

Before: John Harris Terepka
Administrative Law Judge

Held at: New York State Department of Health
259 Monroe Avenue
Rochester, New York 14607
December 2, 2010; January 14, 28, April 5, 2011
Record closed July 1, 2011

Parties: New York State Office of the Medicaid Inspector General
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JURISDICTION

The New York State Department of Health (the Department) acts as the single state agency to supervise the administration of the Medicaid Program in New York State. Public Health Law 201(1)(v); Social Services Law 363-a. The New York State Office of the Medicaid Inspector General (OMIG) is an independent office within the Department, responsible for the Department's duties with respect to the recovery of improperly expended Medicaid funds. PHL 31.

The OMIG issued a final audit report for Odd Fellow & Rebekah Rehabilitation & Health Care Center, Inc. (the Appellant) in which the OMIG concluded that the Appellant had received Medicaid Program overpayments. The Appellant requested this hearing pursuant to SSL 22 and former Department of Social Services (DSS) regulations at 18 NYCRR 519.4 to review the overpayment determination.

SUMMARY OF FACTS

An opportunity to be heard having been afforded the parties and evidence having been considered, it is hereby found:

1. At all times relevant hereto, Appellant Odd Fellow & Rebekah Rehabilitation & Health Care Center, Inc. was a voluntary 120 bed, later 126 bed (Transcript, page 77) residential health care facility located in Lockport, New York and was enrolled as a provider in the Medicaid Program.

2. Auditors from the OMIG reviewed the Appellant's reimbursement from the Medicaid Program for the period April 1, 2000 through December 31, 2005. The Appellant's Medicaid reimbursement for operating costs during this period was based upon its cost report for year April 1, 2000 to March 31, 2001. The OMIG also reviewed

a “rate appeal” (#904053) submitted by the Appellant pursuant to 10 NYCRR 86-2.14 as it applied to the Appellant’s Medicaid reimbursement for the period October 15, 1998 through December 31, 2005. (OMIG Exhibit 4.)

3. On September 24, 2009, the OMIG issued a final audit report (project #06-7527) that identified several disallowances of reported costs. The OMIG advised the Appellant that it had determined to recover Medicaid Program overpayments in the amount of \$1,031,146 on the basis of the audit findings. (OMIG Exhibit 4.) By letter dated October 2, 2009, the Appellant requested this hearing to review the OMIG’s determination. (OMIG Exhibit 1.)

4. The parties have resolved their differences regarding operating expense disallowance 3 and property expense disallowances 2, 3 and 4. (Transcript, pages 13, 95-98, 499-500.) Remaining for disposition in this hearing decision are the following disallowances:

Operating expense disallowance 1. Unsubstantiated reclassification of employee salaries and fringe benefits between departments.

Operating expense disallowance 2. Disallowance of electric expense.

Operating expense disallowance 4. Patient services not included in Medicaid rate.

Operating expense disallowance 5. Overstated employee uniform allowance.

Property expense disallowance 1. Article 28-A mortgage disallowances.

Property expense disallowance 5. Working capital interest expense disallowance.

Property expense disallowance 6. Property insurance expense disallowance.

ISSUES

Has the Appellant established that the OMIG’s audit disallowances were not correct?

APPLICABLE LAW

A residential health care facility (RHCF) can receive reimbursement from the Medicaid Program for costs that are properly chargeable to necessary patient care. 10 NYCRR 86-2.17. As a general rule, these kinds of costs are reimbursable if they are actually incurred and the amount is reasonable. Reimbursable costs include operating expenses such as employee wages and benefits for administration and patient care, supplies, maintenance and utility costs. 10 NYCRR 86-2.10(a)(7). They can also include property costs such as depreciation, leases and rentals, insurance and necessary interest on both current and capital indebtedness. 10 NYCRR 86-2.10(a)(9), 86-2.19(a), 86-2.20(a).

A facility's costs are reimbursed in the form of a per diem rate established by the Department on the basis of costs reported by the facility. A facility's rate is provisional and subject to audit. If an audit identifies errors in the provisional rate, the Department can retroactively adjust the rate. SSL Section 368-c; 10 NYCRR 86-2.7; 18 NYCRR 517.3. The Department may then require the repayment of any amounts not authorized to be paid under the Medicaid Program. 18 NYCRR 518.1.

If the Department determines to recover an overpayment, the facility has the right to an administrative hearing. 18 NYCRR 519.4. At the hearing, the facility has the burden of showing that the determination of the Department was incorrect and that all costs claimed were allowable. 18 NYCRR 519.18(d)(1).

DSS regulations pertinent to this hearing are found at 18 NYCRR parts 517, 518 and 519, and address the audit, overpayment and hearing aspects of this case. Specific Medicaid reimbursement rules pertinent to this hearing are addressed by Department of

Health regulations at 10 NYCRR part 86-2, which concerns reporting and rate certifications; part 452, which outlines basic concepts, reporting principles and specialized reporting areas for nursing home cost reports; parts 454 and 455, which describe functional reporting; and part 456, which sets forth cost-finding practices and procedures. Also applicable, unless otherwise provided in part 86-2, are the principles of reimbursement developed for determining payments under the Medicare Program. 10 NYCRR 86-2.17(a). These are primarily found at 42 CFR chapter IV, and in the Medicare Provider Reimbursement Manual, Part I (PRM-I).

EVIDENCE

Witnesses for the OMIG:

Donald Leathersich	OMIG's coordinator of medical facilities audits, who wrote the final audit report under review. (Transcript, pages 15-16.)
Colleen Quackenbush, R.N.	OMIG auditor. (Transcript, page 196.)
Z. John Zirbel	Director of the OMIG's Rochester office for provider audits. (Transcript, page 318.)

Witnesses for the Appellant:

JoAnn Getman	Appellant's director of nursing. (Transcript, page 376.)
Eugene Urban	Appellant's administrator. (Transcript, page 424.)
Colleen Lofft	Appellant's director of finance. (Transcript, page 446.)
John S. Kropsky	Certified public accountant with the Appellant's current outside auditing firm. (Transcript, pages 501-502.)

OMIG Exhibits 1-17.

Appellant Exhibits C, D, K, M, N, O, P.

A transcript of the hearing was made. (Transcript, pages 1-538.)

Each side submitted two post-hearing briefs.

DISCUSSION

Operating expense disallowances

Operating expense disallowance 1. Unsubstantiated reclassification of employee salaries and fringe benefits between departments.

This disallowance involved the classification, not the amount, of wages and benefits reported by the Appellant. The OMIG did not question the amounts paid for these employees, only the manner in which those amounts were reported on the Appellant's cost report. (Transcript, page 40.)

For Medicaid cost reporting purposes, wages and their corresponding benefits are classified and reported by a facility in different "cost centers" in accordance with the concept of "functional reporting," that is, on the basis of the activities performed by the employee without regard to the organizational framework. 10 NYCRR 452.2(g)(2), 454.2(b). The various functional reporting cost centers are described at 10 NYCRR part 455. The inclusion or exclusion of wages in one cost center or another can affect the amount of reimbursement paid by the Medicaid Program because although the amounts reported may not change, reimbursement may be different depending on the cost centers the wages are reported in.

1. The Appellant reported wages and benefits of its unit assistants (also called unit aides) in the activities cost center. 10 NYCRR 455.14.¹ The OMIG, upon reviewing the job descriptions and functions of these employees, reclassified their wages and

¹ **Activities program.** This functional reporting center must contain all the expenses associated with providing recreational and leisure-time facilities, activities and services to patients both at the facility and on special group activities including trips for recreational purposes, excluding transportation costs. This department is supervised by personnel trained for administration of an activities program. Additional activities encompassed by this functional reporting center include but are not limited to the following: coordinating and scheduling activity programs; arranging for special group activities and trips; arranging for transportation to activities; supervising activity programs; participating in discharge coordination as required by code. 10 NYCRR 455.14

benefits to the skilled nursing facility (SNF) cost center. 10 NYCRR 455.37.² (Transcript, page 23.) The Appellant's attempt to report unit assistants in the activities rather than SNF cost center affected the input price adjustment factor (IPAF) in a way that increased the Appellant's Medicaid reimbursement. (Transcript, pages 32-33, 266.)

The SNF cost center encompasses activities involving direct patient care. The activities cost center is explicitly about "recreational and leisure-time facilities, activities and services to patients." 10 NYCRR 455.14. The OMIG reviewed the Appellant's own job description for unit assistants and correctly determined that their duties primarily involved direct patient care, not recreational and leisure-time activities and services. (OMIG Exhibit 6; Transcript, pages 31-32, 46.)

The Appellant's evidence regarding the nature of these employees' duties failed to call the OMIG's determination into question. The Appellant submitted an employment file for one unit assistant containing a job description that is slightly different from the one originally reviewed by the OMIG auditors. The job description, however, still overwhelmingly described patient care duties belonging in the SNF cost center. (Appellant Exhibit D.) A "skills checklist for the unit assistant" submitted by the Appellant with its response to the draft audit report provides yet another description of

² Skilled nursing facility. This functional reporting center must contain all the expenses associated with providing skilled nursing care to patients on the basis of physicians' orders and approved nursing care plans, when patients require convalescent rehabilitative and/or restorative services at a level less intensive than that of the usual medical acute care. Additional activities include but are not limited to the following: monitoring vital life signs; operating specialized equipment; preparing equipment and assisting physicians during patient examinations and treatments; changing dressings and cleansing wounds and incisions; observing and recording emotional stability of patients; assisting in bathing patients and helping them in and out of bed; observing patients for reaction to drugs; administering specified medication; serving food to patients in their rooms, and feeding patients regardless of location; assisting patients with daily hygiene; answering patient calls; stripping and making beds; and keeping patients' rooms in order. 10 NYCRR 455.37

unit assistant duties, and it too is entirely about direct patient care and fails to even mention activities. (OMIG Exhibit 3, attachment b, page A-5.)

Ms. Getman, the Appellant's director of nursing, characterized the unit assistants' work as "non skilled, non-hands-on-care." (Transcript, page 381.) She said that the employees in question were not certified and did not intend to become certified to provide "hands-on care." (Transcript, pages 385-87.) As Mr. Zirbel pointed out, however, the functional cost center in question is not about skilled, hands-on patient care provided exclusively by licensed or certified caregivers. It is about the patient care activities set forth in the cost center description. The unit assistants may have been lower paid, unlicensed or uncertified employees who generally performed less sophisticated patient care duties, but it is not licensure or certification or lack thereof that matters. It is the functional nature of the duties performed that determines the cost center in which they should be reported, and the unit assistant duties were clearly within the SNF functional center. (Transcript, pages 347-48.)

For example, Ms. Getman testified that one purpose of developing the unit assistant position was to "free up our certified staff to provide hands-on care... We needed someone making beds, passing linens." (Transcript, page 385.) The Appellant's unit assistant work schedule includes serving residents meals and assisting with feeding, making beds, and tidying resident rooms. (Appellant Exhibit I; Transcript, pages 400-401.) All these duties are explicitly included in the section 455.37 SNF functional cost center. None of the duties listed in the work schedule even arguably has anything to do with a section 455.14 activities program.

The Appellant's suggestion that unit assistants could be distinguished from nurse aides, another job title in the SNF cost center, hardly constitutes evidence that unit assistants' duties therefore did not also belong in the SNF cost center. It is, furthermore, no evidence at all that unit assistants' duties were therefore somehow about activities. There may have been two levels of patient care staff, but they were both patient care, not activities, staff. Not only do the unit assistant duties clearly involve patient care, they are, as Mr. Leathersich pointed out, overwhelmingly and decidedly not about recreational and leisure activities. (Transcript, pages 258-59.)

The unit assistant job description includes "[t]ransporting of wheelchair bound residents to/from dining room and activities." (OMIG Exhibit 6.) The Appellant's wild exaggeration that the unit assistants' "primary description was stated as 'assisting with the transfer of residents to and from dining room and activities'" (Appellant brief, page 4) when this is one among sixteen duties listed in that job description, is rejected. The Appellant's claim that this small part of the unit assistant job even constitutes "arranging for transportation to activities" as described in the activities cost center definition is, furthermore, also rejected. (Transcript, pages 262, 293-94, 296.)

The Appellant offered other quibbles that failed to make any persuasive case that even a significant part, much less the majority of these employees' duties were in the activities program functional center. The significance of the color of employee uniforms does not merit discussion. (Appellant brief, page 3.) The Appellant's suggestion that provisions in its employees union contract that treated unit assistants differently in some respects from nursing assistants are relevant to the functional cost reporting issue in this case is rejected. (Transcript, pages 264-66; Appellant brief, page 4.)

Interestingly, Appellant director of finance Colleen Lofft testified that the Appellant reclassified the unit assistants' wages and benefits to the activities cost center on the recommendation of its outside auditors at the time, KPMG. (Transcript, pages 450-51.) KPMG was not routinely engaged for the preparation of the Appellant's cost reports. It was specifically engaged to advise the Appellant in the preparation of this particular cost report because, as Ms. Lofft expressed it, "we knew it was important to be accurate on this report." (Transcript, page 449.)

According to Ms. Lofft, KPMG's recommendation originated in survey deficiencies involving unit assistants that were cited by the Department at another entirely unrelated, indeed unidentified, facility. (Transcript, pages 452-53, 483, 489; OMIG Exhibit 3, attachment D thereto.) KPMG did not review the job descriptions at issue in this audit, nor did the Appellant review the job descriptions of the employees at the other unidentified facility in order to determine what, if anything, they may have had in common with the Appellant's unit assistants for functional cost reporting purposes. (Transcript, pages 483-84, 489-90.) On this meaningless evidence, the Appellant's brief claims "Odd Fellows acted in reliance on DOH's policy allowing for the reclass of 'Unit Assistants' to Activities." (Appellant brief, page 2.) There is no such policy.

The OMIG correctly determined that the duties performed by the unit assistants were far more in line with the part 455 functional cost center description of skilled nursing care than of recreational and leisure-time activities. The Appellant has failed to meet its burden of establishing that the OMIG's determination was incorrect.

2. The Appellant reported forty percent each of the wages and benefits of the minimum data set (MDS) coordinator and of the admissions coordinator in the utilization

review cost center. 10 NYCRR 455.20.³ (Transcript, pages 456-57.) The OMIG reclassified the forty percent portion for the MDS coordinator back from utilization review to the nursing administration cost center, where the main wages of this employee were reported. 10 NYCRR 455.13.⁴ It reclassified the forty percent portion for the admissions coordinator back from utilization review to the social services cost center, where the main wages of this employee were reported. 10 NYCRR 455.21.⁵ In both instances, the Appellant's attempt to report portions of employee wages in the utilization

³Utilization review. This functional reporting center must contain all the expenses associated with providing utilization review. Reference: section 416.9 of this Subchapter. Additional activities include but are not limited to the following: conducting ongoing evaluation of the quality of care provided. This includes periodic review of utilization of bed facilities and of the diagnostic, nursing and therapeutic resources of the residential health care facility with respect to availability of these resources to all patients according to their medical needs, and recognition of the medical practitioner's responsibility for the costs of health care. This review should cover necessity of admission (including concurrent review of admission), length of stay, level of care, quality of care, utilization of ancillary services, professional services furnished, and availability and alternative use of facilities and services. The review committee should include two or more physicians with participation of other professional personnel, or a group outside the facility which is similarly composed and which is established by the local medical society and some or all of the residential health care facilities in the locality, or a group established and organized in a manner approved by the Department of Health that is capable of performing such function. 10 NYCRR 455.20.

⁴Nursing administration. This functional reporting center must contain all the expenses associated with the overall administration and supervision of all nursing services, including all nursing in-service training, scheduling and transferring of nurses between services and units, nursing staff supervision, evaluation and discipline. It includes the work of the director, assistants and/or associates, secretaries, clerks, and all nursing personnel who are responsible for conducting in-service education of nursing personnel, and the following specific job titles: RN Supervisor (supervising two or more units and/or areas), Health Services Supervisor, Director of Nursing Services, and Assistant Director of Nursing Services. Note that nursing in-service education is subject to special rules rather than the reclassification criteria (section 452.4(g)). Additional activities include but are not limited to the following: recommendation of appointments to the nursing staff; definition and execution of the philosophy, objectives, policies and standards for nursing care of patients; participation in community education health programs; participation in patient care review committees; inspection of patient areas to verify that patient needs are met; and coordination of all nursing activities and functions with other residential health care facility functions. 10 NYCRR 455.13.

⁵Social Services. This functional reporting center must contain all the expenses associated with obtaining, analyzing and interpreting social and economic information to assist in diagnosis, treatment and rehabilitation of patients, including counseling of staff and patients in case units and group units, participating in the development of community social and health education programs, coordinating the admission and transfer of patients, coordinating discharges, and providing religious counseling and services. Additional activities include but are not limited to the following: filling out admission forms; scheduling admission times; accompanying patients to rooms or service areas after admission and arrangement of admission details; interviewing patients and relatives in order to obtain social history relevant to medical problems and planning; interpreting problems of social situations as they relate to the medical condition and/or hospitalization of the patient; arranging for post-discharge care of chronically ill patients; and collecting and revising information on community health and welfare resources. 10 NYCRR 455.21.

review cost center effected an increase in its Medicaid reimbursement because it enabled the Appellant to avoid reimbursement ceilings that did not apply to the utilization review cost center. (Transcript, pages 36, 40.)

The OMIG reclassified the wages and benefits back to the cost centers where the bulk of these employees' wages and benefits were reported because the Appellant failed to substantiate the basis for allocating them to more than one cost center. Pursuant to 10 NYCRR 454.2(c), if an employee is performing activities related to more than one function, an allocation between cost centers must be supported by a time study justifying the allocation. The regulation is quite specific about what a time study means and how it is done:

Time studies would be performed for such employees for a two-week period per quarter, for all four quarters in a year. The time study would result in a percentage of employees' hours worked, by function, to total hours worked. These percentages would, for each quarter, be applied to total hours paid for the same employees to arrive at hours paid by function. The results would be totaled for all four quarters and then compared to the estimate of one full-time equivalent of 2,000 hours to determine whether or not a reclassification is required. 10 NYCRR 454.2(c).

The Appellant failed to document that any time studies as required by this regulation were performed. (Transcript, pages 33, 38, 48, 50.)

Rather than perform anything like the time studies required by this regulation, Ms. Lofft, the Appellant's director of finance, simply telephoned the employees in question: "I basically asked them, 'Can you give me an idea of how much of your time is spent on any one of these items,' which I listed out." "These items" apparently meant activities mentioned in a description of the utilization review functional reporting center provided to her by KPMG. In both instances, she said, the answer was 3.5 hours per day. (Transcript, page 465, 484; Appellant Exhibits O, P.)

The Appellant's purported documentation of this allocation consisted of a few incomplete notes from its files, constituting evidence of little more than is already known from the cost report – that the Appellant made the allocation appearing on the cost report. (Appellant Exhibits O, P, Q.) The Appellant was able to establish very little about what the documents it offered were, where they came from or what they meant. (Transcript, pages 466-76.) They hardly constitute documentation of anything, let alone time studies even remotely conforming to the requirements of 10 NYCRR 454.2(c).

The Appellant did not even address, at the hearing or in its briefs, its failure to conduct time studies as required under this regulation. For this reason alone, the OMIG's audit determination is correct and is affirmed.

The Appellant did attempt at this hearing to offer support for the allocation on its merits. The Appellant spent a good deal of time arguing that the MDS coordinator, in particular, performed activities that could be utilization review. (Appellant brief, pages 4-8.) The Appellant made no effort, however to establish that forty percent of either the MDS or admissions coordinators' time was an accurate figure for utilization review. The Appellant's evidence still did not include the required time studies, and so has completely failed even to address the grounds for the OMIG's determination, let alone establish that the allocations it reported were accurate and correct.

As was the case with the unit assistants, the Appellant seems to have gone ahead with this attempted reclassification as a result of advice from KPMG. Ms. Lofft testified “[y]eah, this issue came up with KPMG that typically most facilities have Utilization Review – “ (Transcript, page 477.) KPMG then apparently sent her some material outlining the utilization review function without ever mentioning the need for time

studies. (Transcript, pages 478-79, 482; Appellant exhibits O,P,Q.) In this instance, as with the reclassification of unit assistants to activities, KPMG's advice appears to have been more concerned with strategies to maximize Medicaid reimbursement than with advice about how to properly justify it.

Untangling the differences between the nursing administration and social services cost centers and the utilization review cost center as they are applied to the MDS and admission coordinators' duties is a subject on which neither party made much headway at this hearing. After this audit was commenced, the Appellant submitted a rate appeal requesting yet another reallocation, this time of the entirety of the MDS coordinator's salary to the utilization review center. (Department Exhibit 3, page 6 and attachment F.) The parties can perhaps try to address these issues again in connection with that appeal. For the purpose of this hearing, however, the Appellant has hardly met its burden of proof by defending a forty percent allocation with an argument that one hundred percent is the accurate figure.

As most of these two employees' duties, according to the Appellant's own cost report, belonged in the nursing administration and social services cost centers, then pursuant to 10 NYCRR 454.2(b)(4)(iii)(a) the entirety of their wages belonged in those cost centers in the absence of time studies justifying a different allocation. (Transcript, pages 274-75, 351, 355-56.) The Appellant failed to establish that the OMIG's determination to classify the entirety of these employees' wages in the cost centers where the majority of their wages were reported was not correct.

3. The Appellant reported wages and benefits of its receptionist in the security cost center. 10 NYCRR 455.8.⁶ The OMIG reclassified the wages and benefits to the administrative services cost center. 10 NYCRR 455.5.⁷ Reporting the receptionist's wages in the security cost center increased the Appellant's Medicaid reimbursement because it avoided reimbursement ceilings in the administrative services cost center. (Transcript, pages 41-42, 299-300.)

As it did with the unit assistants, the OMIG reclassified these costs after reviewing the Appellant's own job description for this employee. (Transcript, pages 43, 52; OMIG Exhibit 9.) The job description clearly shows that the bulk of this employee's duties were administrative in nature. Two items on a long list of duties are arguably related to security issues. (OMIG Exhibit 9.) The Appellant's suggestion that these two functions occupied the bulk of the receptionist's time is unconvincing. (Transcript, pages 278-79.)

Mr. Urban's description of the security duties of the receptionist consisted of pointing out that she sat in the lobby, kept an eye on people entering and leaving, and reset the "Wanderguard" system when necessary. (Transcript, pages 432-35.) A

⁶ Security. This functional reporting center must contain all the expenses associated with maintaining the safety and well-being of residential health care facility patients, personnel and visitors, and protecting the facility by patrolling and guarding designated areas. 10 NYCRR 455.8

⁷ Administrative services. This functional reporting center must contain all the expenses associated with the overall management of the facility, including the office of the administrative director, management fees, public relations, auxiliaries or volunteer groups, messenger services, purchasing, governing board, information and paging activities, maintaining all insurance policies (except employee benefit insurance), licenses and taxes, and working capital interest. Additional activities include but are not limited to the following: provision of staff support to the board; charting the flow of patients through residential health care facility services; projecting daily census for budgets; pickup and delivery of mail within the residential health care facility; printing and duplication of forms and reports; operation of the communications system within the facility, including the telephone switchboard and related telephone services; receipt and processing of requisitions; monitoring perpetual supply items; obtaining quotes from selected vendors and monitoring receipt of supplies; receiving, storing and delivering materials, equipment and supplies to various departments; recruitment, employee selection, salary and wage administration; fringe benefit

receptionist's duties will undeniably and necessarily entail some security component – this is the person who sits at the front door and monitors comings and goings. But it is a gross exaggeration of that security component to claim that the main function of the employee is security. The Appellant's own job description clearly shows that many other duties are involved, none of which has anything to do with security and all of which properly belong in the administrative services cost center. (OMIG Exhibit 9.) The Appellant has failed to establish that the OMIG's determination that the receptionist's primary function was in administrative services, and not security, was not correct.

Operating expense disallowance 1 is affirmed in its entirety.

Operating expense disallowance 2. Disallowance of electric expense.

The Appellant included payments on the April 1, 2000 through March 31, 2001 cost report for electric service that was provided outside the cost period. For Medicaid reimbursement purposes, these costs are allowable for the period in which they were incurred, not for the period in which they were actually paid. PRM-I 2302.1. The OMIG disallowed expenses for electric service incurred outside of the cost period. (Transcript, pages 55-56, 182-85; OMIG Exhibit 10.)

The Appellant relies on the requirement that cost reports be completed in accordance with generally accepted accounting principles (GAAP). 10 NYCRR 86-2.4. The Appellant claims that it received the bills during the cost period, and so properly "booked" them under GAAP when it became aware of and paid them. (Transcript, page 187; Appellant brief, pages 9-10.) This is not dispositive of the issue for Medicaid reimbursement purposes. The Appellant ignores the additional requirement that cost

program administration; procurement of temporary help; scheduling and recordkeeping relative to employee visits and pre-employment and post-illness employee physicals. 10 NYCRR 455.5.

reporting be on an accrual basis. 10 NYCRR 452.3(a). The Medicaid reimbursement principle at issue is that the Appellant's allowable cost for electricity in this cost period is the actual cost for the electricity provided during the cost period. Electricity costs recognized during the cost period, but not attributable to electric service provided during the cost period, are not reimbursable for the cost period. (Transcript, pages 184-85.)

As Mr. Leathersich pointed out, if the Appellant wanted these costs recognized for Medicaid reimbursement purposes, it had the option of restating its cost reports to reflect the expenses in the period in which the associated electric service was actually provided. (Transcript, page 184.) If, however, the Appellant chose not to do so, its argument that these costs should be allowed in this cost period simply because they were properly reported under GAAP confuses GAAP with Medicaid Reimbursement principles. (Transcript, pages 183-85.)

Operating expense disallowance 2 is affirmed.

Operating expense disallowance 4. Patient services not included in Medicaid rate.

The Appellant's April 1, 2000 rate computation sheet shows that the ancillary services included in its Medicaid rate, in other words ancillary services for which it was authorized by the Department to claim reimbursement from the Medicaid Program, did not include laboratory or x-ray services. (OMIG Exhibit 11.) The Appellant included costs for laboratory and x-ray services in its cost report. (Transcript, page 63.) The OMIG auditors disallowed these costs that were not authorized to be included in the Appellant's rate. (Transcript, pages 308-10.)

The Appellant appears to argue in its response to the draft audit report that because Medicare regulations require these services be available to Medicare patients, the

Medicaid Program is therefore required to pay the Appellant to provide them. (OMIG Exhibit 3, pages 10-11.) This argument is rejected. The regulatory language on which the Appellant relies states that Medicare Part A services include “services that are generally provided by (or under arrangements made by) SNFs.” 42 CFR 409.20. The cited requirement is about care paid for by the Medicare, not Medicaid Program. The Appellant may have had a responsibility to make “arrangements” for its Medicare patients to obtain these services, but it was not thereby entitled to have the cost of such services included in its Medicaid rate.

At the hearing, the Appellant initially claimed, but failed to offer any evidence to prove, that these costs were actually incurred for Medicaid patients. (Transcript, pages 74, 176.) Mr. Leathersich acknowledged that if there had been some reason to believe that was indeed the case, the OMIG would at least “have taken it into consideration at the time.” He went on to point out, however, that “[w]e had no reason to believe that Medicaid was involved in this anywhere.” (Transcript, page 176.) The Appellant has yet to provide any reason to believe it.

The Appellant’s claim that these were Medicaid recipients turns out to mean only that they are claimed to have been “dual-eligible” for both Medicare and Medicaid. (Transcript, pages 521-22.) The Appellant softened this claim to “nearly all of the residents are dual Medicare/Medicaid eligibles” in the brief. (Appellant brief, page 11.) The claim is certainly plausible, but the Appellant still presented no evidence to support it in connection with the services in question in this case.

Even if the claim about “dual eligibility” is true, the Appellant conceded that the services in question were provided to the residents as Medicare patients, during periods in

which their nursing home care was being paid for by Medicare. (Transcript, pages 520, 522.) Asked “if a facility is required to provide lab and x-ray services for their Medicare patients, they are reimbursed by Medicare for those costs; correct?” Mr. Kropski, testifying on the Appellant’s behalf on this disallowance, answered “yes.” (Transcript, pages 513-14.) The Appellant offered no persuasive explanation why the alleged “dual-eligibility” should somehow make the cost of the services proper costs for inclusion in the Appellant’s Medicaid reimbursement rate as well. “Dual eligibility” and “dual payment” are not the same thing.

Because these services were not properly includable in the Appellant’s Medicaid rate, the appropriate way for them to be paid, if properly payable under the Medicaid Program at all, was as Mr. Leathersich pointed out, as fee for service billed to the Medicaid Program by the actual providers of the services. (Transcript, page 178, 288-89.)

Operating expense disallowance 4 is affirmed.

Operating expense disallowance 5. Overstated employee uniform allowance.

Under the terms of its contract with its employees union, the Appellant was obligated to provide each union employee with a uniform allowance in the amount of \$50 per year. The Appellant had 110 employees eligible for the allowance and so incurred an obligation in the amount of \$5,500 for the year. (Transcript, page 64; OMIG Exhibit 12.) The OMIG recognized and allowed this as a reimbursable cost under the Medicaid Program for employee wages and benefits. The Appellant, however, reported uniform costs in the amount of \$8,219 on its cost report. The OMIG disallowed the difference, in

the amount of \$2,719, as being in excess of the Appellant's reasonable and necessary costs. (Transcript, pages 65-66, 69-71; OMIG Exhibit 13.)

In addition to being in excess of the Appellant's reasonable and necessary costs, Mr. Leathersich testified that during the audit he was given reason to believe that the additional \$2,719 included as a cost during the period in question was not, ultimately, any cost at all to the Appellant. The \$8,129 figure reported by the Appellant apparently included amounts paid by the Appellant for uniforms bought in bulk on the employees' behalf that remained unsold to the employees and in the Appellant's possession. The cost of these uniforms would eventually be recovered by the Appellant from the employees as they used their \$50 union allowances to purchase them. (Transcript, pages 65, 71, 167, 170-71.) The Appellant did not deny that Mr. Leathersich's information was accurate.

The Appellant's apparent position that simply because it spent money to purchase uniforms during the cost period, it was required to report that as a cost, and that this is somehow enough to justify a claim for reimbursement from the Medicaid Program, is without merit. (Transcript, pages 166-67.) The Appellant's argument in its brief based on 10 NYCRR 86-2.18(b) simply starts with the assumption that whatever it spends to purchase uniforms - even expenditures that result in unused inventory the cost of which will eventually be recovered - is an allowable cost for which it is entitled to reimbursement. (Appellant brief, page 12.) The entire question to what extent the cost is reasonable and necessary is simply ignored.

Operating expense disallowance 5 is affirmed.

Property expense disallowances

Property expense disallowance 1. Article 28-A mortgage disallowances.

Before October 1998, the Appellant was an “Article 28-A” financed facility, so-called after PHL Article 28-A, the “nursing home companies law.” (Transcript, pages 76-77.) As an Article 28-A financed facility, the Appellant received Medicaid Program reimbursement pursuant to 10 NYCRR 86-2.19(d) in the form of “debt service,” including amounts required for fees and reserves and other costs, sufficient to carry the cost of the financing. (Transcript, pages 77-78, 153.)

In connection with an extensive renovation involving new construction, the Appellant refinanced its mortgage and paid off the original Article 28-A financing effective October 15, 1998. (Transcript, pages 76, 128, 427.) Because the Appellant was no longer an Article 28-A financed facility, its entitlement to Medicaid reimbursement for mortgage costs was established pursuant to 10 NYCRR 86-2.20, in the form of interest on the new mortgage loan. (Transcript, pages 78, 154-55.)

The change in the nature of its financing required that the Appellant’s property reimbursement be provided in accordance with the applicable reimbursement regulation, 10 NYCRR 86-2.20 and not 10 NYCRR 86-2.19.

In this audit the OMIG determined that Article 28-A debt service paid pursuant to 86-2.19 was eliminated from the Appellant’s reimbursement effective January 1, 1999, not October 15, 1998 when the Appellant ceased to be an Article 28-A financed facility. (Transcript, pages 79, 81.) This audit adjustment corrected the reimbursement error by disallowing Article 28-A costs that had been reimbursed under 86-2.19 for the period October 15 through December 31, 1998. (Transcript, pages 79-80.)

The Appellant did not dispute that the OMIG's overpayment claim was for Article 28-A financing pursuant to section 86-2.19 paid for the period October 15 to December 31, 1998. The Appellant was not entitled to reimbursement under section 86-2.19 during that period because the Article 28-A financing no longer existed during that period. The Appellant claims, however, that the Department intended the Appellant to retain the extra two and one half months of Article 28-A reimbursement anyway, possibly as a way of compensating it for cash flow or other financial difficulties incidental to or associated with the change in reimbursement necessitated by the change in the legal status of the financing. This claim is not based upon any evidence.

The Appellant's burden is to prove why it is entitled to keep Article 28-A reimbursement given for a period in which the financing on which it was based did not exist, and to establish by some evidence that this was what the Department's BLTCR, or "rate setters" intended. There should be some affirmative evidence of such an extraordinary remedy. There is none. At a minimum, there should be some evidence of what, if anything, the Article 28-A reimbursement is claimed to be compensating the Appellant for. There is none. The Appellant has offered nothing but speculation about a few possible explanations. (Transcript, pages 534-35.)

The Appellant suggested that there was a transition period during which the Medicaid rate setters used a special reimbursement methodology for this facility. Mr. Leathersich acknowledged that kind of thing could happen. (Transcript, pages 154-56.) The Appellant also suggested that the duplication in payment was taken into account and compensated for by an adjustment in the Medicaid Transfer Price (MATP) set for the facility at the time of this renovation. (Transcript, pages 163-4; Appellant brief, page 12.)

There is no evidence to support, nor did the Appellant offer any figures to explain or justify these speculations.

The only evidence cited by the Appellant on this issue is a portion of the written rate appeal determination that approved the change in reimbursement. The rate appeal determination stated that Article 28-A reimbursement already paid for the year 1999 was removed from the Appellant's rate. It did not, however, mention the Article 28-A reimbursement already paid for the last two and one half months of 1998. The 1999 rate change summary for the appeal determination then reflects that interest on the new mortgage was allowed and that there were no Article 28-A expenses to reimburse. The 1998 rate change summary for the appeal determination, on the other hand, stated that Article 28-A reimbursement was allowed for the entire year 1998 without mentioning anything about reimbursing interest on the new mortgage. (Transcript, pages 158-61, 534-35; OMIG Exhibit 3, attachment M thereto, page 42 & 1998, 1999 capital calculation worksheets.) The Appellant suggests that these documents show the rate setters made a specific determination to allow both Article 28-A costs and reimbursement on the new mortgage for the period October 15 to December 31, 1998. (Appellant brief, page 12.)

This evidence falls far short of meeting the Appellant's burden of proving that the Department's BLTCR rate setters intended to provide reimbursement simultaneously under 86-2.19 and 86-2.20. The rate setters' actions are more readily explained as simply in error, appropriately corrected by this audit, which is how the OMIG views it. (Transcript, pages 161-62; OMIG brief, pages 32-33.) The Appellant has failed to meet its burden of proving otherwise.

Property expense disallowance 1 is affirmed.

Property expense disallowance 5. Working capital interest expense disallowance.

Interest on current and capital indebtedness can be an allowable cost provided it is reasonable and necessary in accordance with the requirements set forth at 10 NYCRR 86-2.20. This disallowance is about costs reported by the Appellant as interest on working capital borrowing.

1. The Appellant failed to provide any documentation to substantiate payments reported as interest paid to M&T Bank in the amount of \$6,983 for 2004. (Transcript, page 100.)

2. The Appellant reported interest on funds borrowed from its own funded depreciation account in the amount of \$18,639 for 2004, and \$15,075 for 2005. Interest on such borrowing can be an allowable cost. 10 NYCRR 86-2.20(c)(1); PRM-I 226.1. The OMIG disallowed these amounts, however, because the Appellant failed to produce a written agreement documenting the nature, amounts and terms of this borrowing from itself, as is required under PRM-I 202.1. (Transcript, pages 100-101, 109-113.)

3. The Appellant reported interest in the amount of \$13,627 for 2003 and \$7,821 for 2004, paid to an account with Edward Jones Co., which the Appellant claimed as another instance of borrowing from itself for working capital. (OMIG Exhibit 3, page 15; Transcript, page 439.) The OMIG again disallowed these costs because the Appellant failed to document the nature, amounts and terms of the borrowing as required under PRM-I 202.1 (Transcript, pages 101-104.)

The Appellant argued that working capital borrowing was necessary to carry it through the transition period before its new, higher rates attributable to the 1998 renovation were promulgated and paid. (Transcript, pages 129-30, 437; Appellant brief,

page 12.) The Department does, in appropriate circumstances, recognize such a lag in reimbursement as a reason for incurring working capital indebtedness. (Transcript, pages 135-36.) The Appellant claims it paid an interest rate of two percent on this borrowing, which was consistent with prudent and reasonable borrowing. (Transcript, pages 439-40.) Mr. Urban also testified that the Appellant's board, by written resolution, authorized him to conduct the business of the Appellant, in an apparent effort to suggest compliance with the PRM-I 202.1 requirement that "[w]here funds are borrowed from the provider's funded depreciation account or other restricted funds, authorization from appropriate officials of the provider should be on file." (Transcript, page 440; OMIG Exhibit 3, schedule R.)

The Appellant's claims about these matters, however, are not under review because they are not at issue in this hearing. The OMIG's disallowances in this audit were not made because the borrowing was determined to be unnecessary or because it was at an unreasonable rate or not authorized by its board. The OMIG did not reach these questions because there was no documentation to review. The disallowances were made because the borrowing was not documented in the manner required by PRM-I 202.1. (Transcript, pages 130, 142, 148-49, 360-62, 366-67.) The Appellant produced nothing to document the amounts borrowed, the interest rate or any of the other terms of the loans.

It is noted that at the hearing Mr. Zirbel indicated the OMIG later came into possession of information indicating that working capital borrowing, however well documented, would not have been reimbursable because there was no genuine financial need for it. (Transcript, page 343.) The OMIG, however, did not look into the matter

during the audit or raise it in the final audit report. (Transcript, pages 360-61, 366-67.) It is not an issue in this hearing.

The disallowance is affirmed on the grounds stated in the audit report. As the OMIG states in its brief “It is a fundamental, albeit elementary, principle that there must be some proof or evidence of the actual debt that is generating the interest expense.” (OMIG brief, page 34.) The OMIG never reached the issues of appropriate interest rate or other loan terms, board approval, or need to borrow because there was no evidence of a debt in the first place.

This principle is well illustrated by item 1 of this disallowance, the \$6,983 in M&T Bank payments. The Appellant reported the payments as interest and defended them as such along with the other disallowed amounts throughout this audit. (OMIG Exhibit 3, pages 14-16), only to concede in its post hearing brief that they were nothing of the kind. The Appellant, perhaps after finally looking into the matter only after this hearing closed, has discovered that these turn out to be payments for bank fees, not interest, and now concedes this portion of the audit disallowance. (Appellant brief, page 13.) The Appellant’s concession at this late stage of the proceedings provides little encouragement to overlook its inability to produce adequate documentation for the remainder of these reported interest expenses.

Property expense disallowance 5 is affirmed.

Property expense disallowance 6. Property insurance expense disallowance.

Property insurance can be allowable cost. In this instance the OMIG reviewed the Appellant’s property insurance reimbursement and determined that its actual property insurance costs for 2004 were \$2,378 less than was allowed in its 2004 rate. (Transcript,

pages 118-19; OMIG Exhibit 15.) The OMIG disallowed reimbursement for the reported costs that were not actually incurred. The Appellant offered neither evidence nor argument to meet its burden of establishing that the audit determination was incorrect. 18 NYCRR 519.18(d)(1).

Property expense disallowance 6 is affirmed.

DECISION: Operating expense disallowance 1 is affirmed.
Operating expense disallowance 2 is affirmed.
Operating expense disallowance 4 is affirmed.
Operating expense disallowance 5 is affirmed.

Property expense disallowance 1 is affirmed.
Property expense disallowance 5 is affirmed.
Property expense disallowance 6 is affirmed.

This decision is made by John Harris Terepka, Bureau of Adjudication, who has been designated to make such decisions.

DATED: Rochester, New York
July 8, 2011

_____/s/_____
John Harris Terepka
Administrative Law Judge