PROVIDER REIMBURSEMENT REVIEW BOARD
HEARING DECISION

99-D3

PROVIDER -
High Tech Home Health, Inc.
Palm Beach Gardens, FL

Provider No. 10-7281

vs.

INTERMEDIARY -
Ætna Life Insurance Company

DATE OF HEARING-
November 7, 1996 &
February 18, 1997

Cost Reporting Period Ended -
December 31, 1993

CASE NO. 95-2373

INDEX

ISSUES:[1]

1. Was the Intermediary's adjustment to employee salary and benefits proper?
2. Was the Intermediary's adjustment to advertising proper?
3. Was the Intermediary's adjustment to deferred compensation expense proper?
4. Was the Intermediary's adjustment to payroll benefits/profit sharing proper?
5. Was the Intermediary's adjustment to dues and subscriptions expense proper?
6. Was the Intermediary's adjustment to auto insurance and auto lease expense proper?
7. Was the Intermediary's adjustment to liability insurance expense proper?
8. Was the Intermediary's adjustments to professional accounting expense proper?
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10. Was the Intermediary's adjustment to auto mileage/allowance expense proper?
11. Were the Intermediary's adjustments to staff travel/education expense proper?
12. Were the Intermediary's adjustments to education/other expense proper?
13. Were the Intermediary's adjustments to miscellaneous expense proper?
14. Was the Intermediary's adjustment to bonus expense proper?
15. Was the Intermediary's adjustment to owner's compensation expense proper?
16. Was the Intermediary's adjustment to overhead expense proper?
17. [withdrawn).

STATEMENT OF THE CASE AND PROCEDURAL HISTORY :

High Tech Home Health, Inc. ("Provider") is a proprietary home health agency located in Palm Beach Gardens, Florida. The Provider's fiscal intermediary for the year at issue was Ætna Life Insurance Company ("Intermediary"). Since 1989, when the Provider was accepted as a participant of the Medicare program, the Provider was required to and did submit annual Medicare cost reports to its Intermediary. The Intermediary, charged with the responsibility of ensuring that the Provider's claimed costs complied with relevant Medicare law, regulation, and policy, reviewed the Provider's costs reports and determined the Provider's allowable costs. Upon completion of its review for fiscal period ending December 31, 1993, the Intermediary issued a formal Notice of Program Reimbursement (NPR) to the Provider on August 31, 1995 indicating that the Medicare program overpaid the Provider $546,218. [2]

The Provider appealed most of the adjustments on the NPR to the Provider Reimbursement Review Board ("Board") and has met the jurisdictional requirements of 42 C.F.R. § 405.1835-.1841. A hearing was held on November 7, 1996 and on February 18, 1997.[3] At the time of the hearing, the Provider had appeals, with some issues similar to those in the present case, pending before the Board. At the request of the Provider at the first

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[1] The issues in this case have been renumbered several times. The issues as numbered correspond to the Board's December 9, 1996 correspondence to the parties.

[2] See Provider Exhibit 1, Notice of Amount of Program Reimbursement (NPR). The Provider did not appeal all the adjustments in the NPR. Therefore the amount of adjustments at issue in this case does not equal $546,218.

[3] The November 7, 1996 transcript will be referred to as "Tr. I". The February 18, 1997 transcript will be referred to as "Tr. II".

day of the hearing, these decisions, along with the parties' post hearing briefs for those decisions were incorporated into the record of this appeal.[4]

The Provider was represented at the hearing by Thomas J. Larkin, Esquire, Executive Director of High Tech Home Health, Inc. The Intermediary was represented by Thomas P. Ward, Esquire, and Maureen A. Malony, Esquire, of Beck, Chaet, Loomis, Malony & Bamberger, S.C.

ISSUE 1- EMPLOYEE SALARY AND BENEFITS

Facts:

While in the process of auditing the of the cost report and reviewing supporting documentation, the Intermediary found documentation in the personnel file of one of the Provider's Home Health Aide Coordinators indicating that the coordinator worked in a doctor's office for 2 days in 1993. The Intermediary could not find any time records or other documentation that would support the employee's full time status at the Provider, or split between the Provider and the doctor's office. Therefore, the Intermediary disallowed 100 percent of the employee's salary and benefits, or $46,024.

PROVIDER'S CONTENTIONS:

The Provider contends that the Intermediary's disallowance of salary and benefits of an employee for services not related to patient care and for lack of adequate documentation is similar to the intake coordinator adjustment (Issue # 9) in that the $46,024 adjustment was based on a single letter of thanks in the nurse's file referencing two days.[5] The Provider argues that the Intermediary had no additional information available on which to base its adjustment. The nurse in question had, prior to joining the Provider, worked in staffing the previous year, 1992. The Provider notes that this is the same issue as in its December 31, 1992 appeal where the Provider moved two full-time employees to half-time during the year and paid the employees from an affiliate company.[6] The Provider notes that in the 1992 case, the Intermediary denied all of the salaries and benefits for the entire year because the employees did not keep time sheets when they were full-time in the home health agency. The Provider argues that the Intermediary denied the employee's entire 1993 compensation in the current issue based on a possible two day problem. The Provider contends that the Intermediary refused to consider any non-time sheet documentation such as visits made.

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4 See Tr. I at 8. High Tech Home Health, Inc, v. Ætna Life Ins, Co., PRRB Decision No. 97-D9, November 22, 1996, Medicare & Medicaid Guide (CCH) ¶ 44,935; HCFA Adm. Declined Rev., January 7, 1997; High Tech Home Health, Inc. v. Ætna Life Ins. Co,, PRRB Decision No. 97-Dl0, November 22, 1996, Medicare & Medicaid Guide (CCH)
¶ 44,936, HCFA Adm. Declined Rev., January 7, 1997

5 Provider Exhibit 17.

6 Provider Post Hearing Brief at 10. The Provider is referring to Issue # 6, Lack of Documentation, in High Tech Home Health, Inc, v. Ætna Life Ins. Co,, PRRB Dec. No. 97-Dl0, November 22, 1996, Medicare & Medicaid Guide (CCH)¶ 44,936. The Board affirmed the Intermediary's adjustment.

The Provider further contends that in 1993, the employee in question performed visits, worked in the office doing patient care coordination and Quality Assurance, and also delivered P.O.T.'s and telephone orders to physicians' offices for signature.[7] The Provider also asserts that this employee did patient intakes as well. [8]

The Provider acknowledges that the employee had worked for its staffing and private duty company in 1992. [9] The Provider argues that although it has no recollection of what the employee did in the doctor's office those 2 days, a letter in the personnel file is insufficient documentation to disallow 100 percent of this employee's salary and benefits. The Provider also points out that the anonymous program integrity referral in which it was stated that this employee worked 4½ days per week for a doctor is physically refuted by the absolute volume of allowable work performed by the employee and by unrefuted testimony. [10] The Provider contends the adjustment should be reversed based on Provider Reimbursement Manual (HCFA Pub. 15-1)
§ 2102.2 . The Provider also cites In Home Health v. Blue Cross and Blue Shield of Iowa , PRRB No. 96-D36, June 10, 1996, Medicare & Medicaid Guide (CCH) ¶ 44,477, rev'd HCFA Admin., August 4, 1996, Medicare & Medicaid Guide (CCH) ¶ 44,594, and In Home Health v. Donna Shalala in Federal District Court, District of Minnesota, Third Division, Civil Case No. 3-94-CV- 1504 RHK/FLN in support if its position.

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that based on information reviewed and the fact that the Provider failed to keep time records to support allowable versus non-allowable time for the employee, an adjustment should be made to disallow 100% of this employee's salary and benefits. The Intermediary maintains that it could not find any time records or other credible documentation which would support that the employee worked full time for the Provider. [11] The Intermediary also contends that the Provider admitted that it could offer "no good explanation" for the 2 days the employee worked in the doctor's office. [12] In addition, the Intermediary points out that documentation submitted by the Provider during the discovery phase of this appeal appears to prove that the employee was paid on a per visit basis in addition to her salary. [13]

The Intermediary points out that the Provider offered certain exhibits (Provider Exhibits 18,19,20) in its Position Paper and at the hearing to support its position that the employee worked full time at the Provider. [14] However, it is the Intermediary's position that the exhibits still fail to give the Intermediary any documented method with which to apportion the employee's time between reimbursable and non-reimbursable hours or document that the employee worked full time for the Provider. The Intermediary contends that the Provider's exhibits, taken in whole or in part,

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7 Provider Post Hearing Brief at 11. See also Provider Exhibits 18, 19.1 and 20.

8 Tr. I at 45-50.

9 Provider Post Hearing Brief at 11.

10 Tr. I at 50.

11 Provider Exhibit 17; Tr. II at 13.

12 Provider Exhibit 17.

13 Tr. II at 15.

14 Id. at 15-18.

simply fail to give it any method with which to apportion the employee's reimbursable and nonreimbursable time. [15] The Intermediary maintains that the lack of documentation for hours worked and the documentation that the employee was not engaged in services related to patient care obligated the Intermediary to make the adjustment. The Intermediary cites 42 C.F.R. §§ 413.9 and 413.24, and HCFA Pub. 15-1 §§ 2102.3 and 2304 in support of its adjustment.

ISSUE 2 - ADVERTISING

Facts:

The Intermediary disallowed $1620 for an advertisement in the Palm Beach Medical Society publication " On Call". The Intermediary asserts the advertisement is promotional in nature.

PROVIDER'S CONTENTIONS:

The Provider contends that under 42 C. F. R § 413.9(c)(3) it is entitled to reasonable costs of providing services to beneficiaries including all necessary and proper expenses incurred in furnishing services, including administrative costs and both direct and indirect costs. The Provider refers to HCFA Pub. 15-1, § 2136.1 which states in relevant part:

> [c]ost of activities involving professional contacts with physicians, hospitals, public health agencies, nurses' associations, State and county Medical societies, and similar groups and institutions, to apprise them of the availability of the provider's covered services are allowable. Such contacts make known what facilities are available to persons who require such information in providing for patient care, and serve other purposes related to patient care, e.g., exchange of medical information on patients in the provider's facility, administrative and medical policy, utilization review, etc.

Id. (emphasis added)

The Provider contends that it advertised in the Palm Beach County Medical Society monthly journal appraising physicians of the availability of the Provider's covered services. The Provider contends that although it made $8,665 in self denials for promotion in FYE 12/31/93, the $1620 is an allowable expense. The Provider argues that this advertising expense is insignificant and was placed in the county physicians' bulletin to make known the availability and existence of the Provider. [16] The Provider rejects the Intermediary's position that the words in the advertisement "JCAHO accredited" are troublesome. [17] The Provider contends that the reference to JCAHO in the advertisement tells the physician community that the Provider follows certain standards of administrative and medical policy and utilization review which are specifically defined as allowable advertising costs. Finally, the Provider points out that although a county medical society is specifically listed in the regulations regarding advertising, the Intermediary denied any knowledge as to that effect. [18]

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15 See Intermediary discussion of Provider support in Intermediary's Post Hearing Brief at 4-5.

16 Provider Post Hearing Brief at 13.

17 Id.

18 Tr. II at 42.

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends it disallowed $1620 in payments for the display of an advertisement in the Medical Society's publication, "On Call"[19], because it considered the ad promotional in nature. The ad states, "High Tech Home Health, Inc. is a Medicare agency fully committed to bringing you the best home health programs available to your individual patient needs." The Intermediary believes the ad was for soliciting referrals and therefore promotional in nature. Furthermore, the Intermediary maintains the advertisement advertises for non-Medicare reimbursable services.[20] The Intermediary believes its adjustment is in accordance with the regulations. The Intermediary references 42 C.F.R. § 413.9 and HCFA Pub. 15-1 § 2136 in support of its adjustment. [21]

ISSUE 3 - DEFERRED COMPENSATION
Facts:

The Intermediary determined during its examination that the Provider had accrued $80,000 for a deferred compensation plan covering its owners. The Intermediary disallowed this cost because the liability had not been liquidated timely by the Provider.

PROVIDER'S CONTENTIONS:

The Provider argues that the Intermediary's $80,000 disallowance of deferred executive compensation for lack of funding is a direct result of the Intermediary's wrongful accounting practices which have been before the Board. [22] The Provider contends that HCFA Pub. 15-1
§ 906.4 allows funding by negotiable instrument on demand in the future, which means that the deferred compensation expense was timely funded. The Provider asserts that the Intermediary prevented it from turning the negotiable instruments into an annuity payable in the future by deliberately under funding the Provider in 1992, 1993, and 1994.[23]

INTERMEDIARY'S CONTENTIONS:

The Intermediary argues that pursuant to HCFA Pub. 15-1, § 2140.3, a deferred compensation plan should designate the requirement for vested benefits and provide the basis for computation of the amount of benefits to be paid. The Intermediary contends the Provider's plan does not meet these requirements. The Intermediary refers to testimony at the hearing in which the Provider admitted that, although an owner had received a note for deferred compensation, that note was never liquidated and the Provider's owners have never actually received any deferred compensation. [24]

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19 See Provider Exhibit 33.

20 Tr. II at 29-35.

21 Intermediary Position Paper at 3.

22 Provider Post Hearing Brief at 14. The Provider is referring to Issue #3, Short-term Liabilities, for FYE 12/31/92, in High Tech Home Health. Inc. v. Ætna Life Ins. Co., PRRB Decision No. 97-Dl0, November 22, 1996, Medicare & Medicaid Guide (CCH) ¶ 44,936. The Board affirmed the Intermediary's adjustment on this issue.

23 Id.

24 Tr. I at 50.

Because the plan was not properly funded, did not state the requirements for vesting, or provide a basis for computation of the amount of benefits, the Intermediary disallowed $80,000 the Provider had accrued for its deferred compensation plan covering the owners.

The Intermediary also points out that in the Provider's Position Paper, the Provider contended that the adjustment in this issue is closely tied to the "short term liabilities" adjustment occurring in FYE 12/31/92. [25] The Board held that the "short term liabilities" adjustment occurring in FYE 12/31/92 was proper. [26] Therefore, the Intermediary maintains that the Board's prior decision should be viewed as evidence that the adjustment in this case was proper.

ISSUE 4 - PAYROLL BENEFITS/PROFIT SHARING

Facts:

During its examination of the Provider's costs, the Intermediary found that only a portion of the profit sharing expense could be verified as being funded timely. The Intermediary allowed $97,574 of this amount and disallowed $1,703, asserting this amount was a 1994 expense. [27]

PROVIDER'S CONTENTIONS:

The Provider contends the $1703 amount disallowed was the life insurance portion of the profit sharing plan for two employees in 1993. [28] The Provider argues that it was a 1993 expense, paid in 1993, therefore, it should be an allowable expense on the 1993 cost report. [29] The Provider rejects the Intermediary's argument that the $1703 payment in 1993 was for a 1994 expense. The Provider maintains that since the cost was not included on the 1994 cost report and that cost report was audited and closed, there would be an economic loss to the Provider.

INTERMEDIARY'S CONTENTIONS:

The Intermediary maintains that the $97,574 it allowed represents the Provider's 1993 plan contribution. [30] The Intermediary contends the $1703 disallowance was a payment paid for coverage through December 28, 1994. [31] The Intermediary notes that the disallowed amount could be considered reimbursable in FYE 12/31/94 if it were supported by proper documentation. [32]

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25 Provider Position Paper at 19.

26 High Tech Home Health, Inc. v. Ætna Life Ins. Co., PRRB Dec. No. 97-Dl0, November 22, 1996, Medicare & Medicaid Guide (CCH) ¶ 44,936.

27 The Intermediary modified its original adjustment by $8411.86. A check to support this amount was subsequently provided by the Provider. See Tr. II at 45-46.

28 Provider Post Hearing Brief at 16.

29 See Provider Exhibit 24 at 100-103; 6.10 4/8.

30 Intermediary Post Hearing Brief at 8; Provider Exhibit 24.

31 Tr. II at 47.

32 Id. at 50.

ISSUE 5 - DUES AND SUBSCRIPTION EXPENSE

Facts:

The Intermediary made a $194 adjustment to dues and subscriptions. The Intermediary maintains that $115 of this amount was not supported by any documentation and the balance of $79 was a personal expense and not related to patient care.[33]

PROVIDER'S CONTENTIONS:

Regarding the $79 adjustment, the Provider contends that the subscription for *Business Week* was an ordinary and necessary business expense because long-term decisions, such as investing in new computer software for a pen-based clinical system, are impacted by non-Medicare happenings in government and society. [34] With regard to the $115 disallowance, the Provider contends these were medical books and manuals which were ordered by telephone based on a mailed sales publication and paid for by credit card. No invoice was generated and no shipping order was kept. The Provider asserts that the Intermediary wrongly refused to accept any documentation except the invoice. [35]

INTERMEDIARY'S CONTENTIONS:

An adjustment was made in the amount of $79 for a subscription to *Business Week*, as it was determined to be a personal expense and not related to patient care. The Intermediary notes that the invoice for the subscription was made out to the owner and not to the Provider. Because *Business Week* is a general publication, it was considered to be a personal expense.

The Intermediary also disallowed $115 in dues and subscriptions for which there was inadequate documentation. [36] The Intermediary contends the Provider failed to offer any evidence at the hearing, either in the form of live testimony or documentation, regarding this $115 adjustment. The Intermediary therefore requests the Board to consider the Provider's appeal of this issue waived.

ISSUE 6 - AUTO INSURANCE AND LEASE EXPENSE

Facts:

The Intermediary removed the cost of the auto insurance expense ($6,191) and the cost of the auto lease expense ($5,445) from the Provider's cost report because it believed there was not adequate documentation to support these costs.

PROVIDER'S CONTENTIONS:

The Provider notes that it charged the Program the cost of one leased car (Lexus) in 1993 and also charged the Program the cost of auto insurance for two cars (Lexus & Pontiac) in 1993. The Provider contends that the insurance expense is an ordinary and necessary business expense, allowable as an administrative cost. The Provider maintains that mileage logs are not necessary for insurance expense to be an allowable cost since it is either allowable as an

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33 Tr. II at 53.

34 Tr. I at 15.

35 Provider Post Hearing Brief at 16.

36 Provider Exhibit 34; Tr. II at 53-55.

allowable automobile expense or as an employee benefit. [37]

The Provider contends it produced a mileage log for the Lexus. The Provider acknowledges that while the log did note long trips, it was totally lacking daily mileage entries. [38] The Provider notes that it had already self denied one-third of these expenses as a personal expense. The Provider points out that the logs used in 1993 were essentially the same kind used in the prior year and that the Intermediary did not make any adjustments in 1992. The Provider also believes that the Internal Revenue Service does not require the recording of daily local mileage. [39]

INTERMEDIARY'S CONTENTIONS:

The Intermediary notes the Provider's contention that it leased vehicles for agency employee use. The Intermediary requested documentation to support the costs of these leased vehicles. [40] Specifically, with regard to each of the Provider's vehicles, the Intermediary asked for: a statement as to whether the vehicles were leased or owned, copies of lease agreements, mileage logs, a statement of reasons for the autos being leased, and the employees who are approved for driving them. [41] Due to the Provider's failure to provide the Intermediary with adequate data to support the costs of these vehicles in the cost report, the Intermediary removed the cost of the auto insurance ($6,191) and the cost of the auto lease ($5,445) from the Provider's cost report. [42] Although the Provider claimed that the Intermediary had the leases in its permanent file, the Intermediary was requesting information as to vehicles leased in FYE 12/31/93, not prior years. The Intermediary points out that the Provider contradicts its own argument in its Position Paper by admitting that it bought the automobile at issue without submitting any documentation as to when it did. [43]

ISSUE 7 - LIABILITY INSURANCE
Facts:

The Provider purchased a liability insurance policy for $23,204 that covered the Provider and other non-HHA entities owned by the Provider. The Intermediary maintained the Provider failed to submit documentation which showed what portion of the cost of the liability insurance policy went to cover the Provider and what portion of the cost went to cover the cost of non-HHA entities owned by the Provider. The Intermediary

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37 Provider Post Hearing Brief at 18.

38 Provider Post Hearing Brief at 17.

39 Id. at 17-19.

40 Tr. II at 61-62.

41 Id.

42 Provider Exhibit 25.

43 Provider Position Paper at 22.

allocated the premiums between the entities in proportion to the costs incurred by each corporation. [44] The Intermediary allowed $12,721 for liability insurance, but disallowed $10,483.50. [45]

PROVIDER'S CONTENTIONS:

The Provider explains that each year it accrues liability insurance expenses based on estimated total liability insurance expense as a function of the current year's number of transactions. The Provider contends the adjustment in this issue is the result of the Intermediary's failure to use accrual accounting and to separate the fiscal years. [46] The Provider also explains that the 100 percent increase in cost is due to its increased visit volume. The Provider maintains the allocation among its various businesses was done by its insurance company based on the type of work performed.[47] The Provider takes exception to the Intermediary's attempt to allocate the costs based on total costs of the businesses and to the Intermediary's refusal to use a letter from the insurance company which details the breakdown.[48]

The Provider contends that ignoring the letter because it is not an invoice violates the Medicare regulations requirement to audit the records of providers as those records are normally kept in the ordinary course of business. 42 C.F.R. §§ 413.20 and 413.24. The Provider maintains that liability insurance is an allowable administrative cost related to patient care under HCFA Pub. 15- 1,
§ 2102.2 and that the disallowance is arbitrary and capricious.

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that the Provider failed to submit documentation which showed what portion of the cost of the liability insurance policy went to cover the Provider and what portion of the cost went to cover the other business entities owned by the Provider. The Intermediary acknowledges that although the Provider did offer a letter from an insurance service representative regarding this adjustment, the letter does not show that the Provider actually paid for the policy referred to in the letter or for what time period the policy, referred to in the letter, was to cover. [49]

Therefore, the Intermediary explains that it had to rely on an alternative way to allocate the insurance expense between the different entities. The premiums were allocated between the entities in proportion to the costs incurred by each corporation.[50] The Intermediary allowed $12,721 for liability insurance, but disallowed $10,483.50. It is the Intermediary's position that the Provider is mandated to have adequate documentation to support any cost it claims on the cost report. The Intermediary is relying on 42 C.F.R. § 413.24 and on HCFA Pub. 15-1 § 2304 to make this adjustment.

ISSUE 8 - PROFESSIONAL ACCOUNTING EXPENSE

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44 Provider Exhibit 27; Tr. II at 67.

45 Id.

46 Provider Post Hearing Brief at 19.

47 Provider Exhibit 27 at 100-101.

48 Tr. II at 65-70.

49 Tr. II at 68, 72-73.

50 Id. at 67; Provider Exhibit 27.

Facts:

There were three components to the Intermediary's adjustment on this issue. [51] The first component of the adjustment was for $24,500 which the Intermediary alleged made up two year-end accruals not supported by documentation. [52] The second component was a $2,490 adjustment which the Intermediary alleged was not related to patient care. The third component was a $7,775 adjustment which the Intermediary contends was a 1994 expense.

PROVIDER'S CONTENTIONS:

The Provider contends that $20,000 of the accrual which the Intermediary disallowed was for legal expenses of its FYE 1993 appeal.[53] The Provider argues that the Intermediary's refusal to allow the accrual violates the principles of accrual accounting and economically harms providers because they eventually run out of cash and are not reimbursed for legal expenses.

The Provider explains that the $2,490 was for legal expense, related to the Provider's name, High Tech Home Health, Inc.[54] The Provider contends the expense was generated in the normal course of business and is related to patient care as that term is defined the same way as occupational licenses relate to patient care, a necessary cost of doing business. HCFA Pub. 15-1 § 2102.2

Finally, the Provider explains that the $7,775 was for accrued accounting expenses to prepare the PIP report for the 4th QTR of 1993; 1993 tax returns, 1099s and W-2s; and work on the 1993 cost report. The Provider asserts these expenses are proper 1993 expenses under accrual accounting. [55]

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that two year-end accruals were not supported by documentation. [56] The total amount of this first adjustment is $24,500.

The second adjustment involves legal costs concerning trademark registration, which is considered a stockholder expense and not related to patient care.[57] The Intermediary points out that Provider Exhibit 31 shows that the Provider incurred $2,490 in legal costs to review a trademark opinion for "A Professional Nurse," a home health agency other than the Provider. The Intermediary contends that the Provider failed to submit anything which would document the relationship between patients of "A Professional Nurse" and patients of High Tech Home Health. Therefore, the Intermediary reasoned that even if this expense would relate to patient care, it would not be related to

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51 Provider Exhibit 31.

52 Intermediary Post Hearing Brief at 12.

53 Provider Post Hearing Brief at 20.

54 Tr. I at 31.

55 Tr. II at 84-88.

56 Provider Exhibit 31.

57 Tr. II at 76-77.

the care of the Provider's patients, but related to the care of the patients of "A Professional Nurse." [58] Therefore, the Intermediary disallowed this cost.

Finally, there was an adjustment for $7,775 for accounting services that were not provided and paid for in FYE 12/31/93, but were provided and paid for in FYE 12/31/94. [59] The Intermediary contends this expense should be removed from the FYE 12/31/93 cost report and included in the FYE 12/31/94 cost report.

ISSUE 9 - INTAKE COORDINATORS SALARIES AND BENEFITS

Facts:

The Intermediary disallowed 100 percent, or $123,736, of the compensation claimed by the Provider for its intake coordinators.[60] The Intermediary alleges that the Provider was unable to produce time records or activity logs to support the activities of its intake coordinators. Additionally, upon review of the Provider's education and travel account, the Intermediary found that intake coordinators were performing patient solicitation activities.

PROVIDER'S CONTENTIONS:

The Provider asserts that the cost of home health coordination activities which ease the patient's transition from the hospital or SNF to the home under the care of an HHA are allowable. See HCFA Pub. 15-1 § 2113.1 The Provider also points out that education and liaison activities permit the HHA to establish ties with the rest of the health care system. Id. The Provider also acknowledges that costs incurred by a home health agency for personnel performing duties in the hospital or SNF which are primarily directed toward patient solicitation are unallowable costs for Medicare reimbursement purposes. See HCFA Pub. 15-1 § 2113.2.

The Provider contends that the Intermediary's disallowance of salaries and benefits of the intake coordinators due to performance of non-allowable marketing activities and for the lack of documentation is the continuation of the fraud by the Intermediary on the Provider based on the audit results of January, 1994. [61] The Provider contends that since it did not have time sheets for the intake coordinators, the Intermediary disallowed 100 percent of the salaries and benefits. The Provider notes that the intake coordinators' adjustment for its FYE 12/31/92 appeal is currently before the Board.[62]

The Provider contends the adjustment was based on a statement by the Provider's owner that intake coordinators used the Yellow Pages to find addresses of physicians who did not use the Provider. The Provider asserts the Intermediary's auditor misstated this conversation with the Provider's owner regarding the intake

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58 Id. at 76.

59 Provider Exhibit 31

60 Provider Exhibit 13.

61 Provider Post Hearing Brief at 24.

62 Id. at 25; The Provider is referring to Issue # 2 in High Tech Home Health, Inc., v. Ætna Life Ins. Co., PRRB Dec. No. 97-Dl0, November 22, 1996, Medicare & Medicaid Guide (CCH) ¶ 44,936. In this decision, the Board affirmed the Intermediary's adjustment disallowing the entire compensation of the Provider's intake coordinators.

coordinators' use of the Yellow Pages. The Provider argues that this one misstatement was used to make adjustments in 1992 and 1993.[63]

The Provider contends that the Intermediary ignored key documentation to support the salaries, including intake sheets, time sheets prepared after the Intermediary's audit, and the educational presentations of the coordinators to physicians who were referring to the Provider.[64]

The Provider disputes the Intermediary's argument that its records must be contemporaneous. The Provider contends there are no regulations which require it to keep contemporaneous records for its intake coordinators.[65]

The Provider refers to VNA of Greater St. Louis, St. Louis, Missouri v. Blue Cross Health Services, Inc., of St Louis, Missouri, PRRB Case No. 86-D47, December 31, 1985, Medicare & Medicaid Guide (CCH) ¶ 35,467 (1985) HCFA Admin. Declined Rev., February 20, 1986, St. Louis, in which the provider in this case was not required to have the level of documentation the Intermediary is requiring in the present case. The Provider explains that in St. Louis, the intermediary disallowed 100 percent of the costs of consultants whose duties were essentially identical to the coordination activities engaged in by the intake coordinators in the present case. In what was the final decision of the agency, the Board reversed the adjustment in full, finding that a document created in 1983 based on the recollections of the consultants which summarized their activities and allotted percentages of time to each of those activities reliably documented the consultants' activities in 1978, 1979, and 1980. The Provider contends that it prepared the activity sheets for 1993, in February 1994, immediately after the Intermediary's audit for FYE 12/31/92 in January, 1994. The Provider contends that its activity sheets prepared from patient charts, expense reports, bills and memory are far more contemporaneous than those used in St. Louis, which the Secretary accepted.

In summary, to support the allowability of its intake coordinators costs, the Provider is relying on activity sheets prepared after the January, 1994 audit of its FYE 1992 cost report and on HCFA Pub. 15-1, §§ 2102.3 and 2113.

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that based on the results of its review, it determined that the Provider failed to submit sufficient documentation to support the intake coordinators' salaries and benefits. Although time records and activity logs were requested for the months of April and November for all intake coordinators, the Provider failed to provide any time records.[66] The Intermediary maintains there was absolutely no contemporaneous records to show what the intake coordinators were doing or the services that they were performing.[67]

The Intermediary notes that the documentation which the Provider did supply was constructed after the fact and, in reviewing this documentation, the Intermediary found inconsistencies in these "activity logs." For example, when comparing the date of intake of a patient as listed in the Provider's log with that of the intake coordinator's activity

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63 Id. at 25.

64 Provider Post Hearing Brief at 25.

65 Id. at 26.

66 Provider Exhibit 13.

67 Tr. II at 91; Provider's Position Paper at 15 (pointing out that the Provider did not have the time sheets which the Intermediary requested).

log, the dates do not coincide with each other.[68] The Intermediary also contends that non-allowable activities such as patient solicitation were being performed by the intake coordinators.[69] Finally, as with the intake coordinators' salaries in FYE 12/31/92, no time records were made available to support the activities of certain part-time workers.[70]

The Intermediary contends that the Provider has admitted that it did not have the time sheets which it requested.[71] The Intermediary rejects the Provider's argument that it would only accept time sheets. The Intermediary testified that it would have accepted any suitable documentation in place of time sheets if such documentation showed the services in which the intake coordinators performed were reimbursable.[72] The Intermediary maintains that the problem with the Provider's documentation had nothing to do with the fact that it was not in the form of time sheets. Rather, the documentation which the Provider submitted to the Intermediary evidenced that the intake coordinators performed both reimbursable and non-reimbursable activities but did not give the Intermediary any way to allocate the amount of time the intake coordinators were involved in providing reimbursable services to the Provider.[73]

The Intermediary notes that the Provider contends that the issue of intake coordinators' salaries is the same with respect to FYE 12/31/92 and FYE 12/31/93.[74] In fact, the Intermediary points out that the Provider explicitly stated that nothing has substantially changed with regard to the intake coordinators between 1992 and 1993.[75] Based on the Provider's admissions and lack of documentation, the Board should find that the Intermediary's adjustment with regard to the Provider's intake coordinator's salaries is proper.

The Intermediary notes that the Board has already ruled in favor of the Intermediary with regard to this issue in prior decisions.[76] The Board ruled that it was persuaded by the Intermediary's argument that although the Provider submitted some evidence on some expenses, that the Provider failed, based on a lack of supporting documentation, to prove that the entire amount of the Provider's expenses were reimbursable. The Board specifically found that, because the Provider did not maintain time sheets for the year in dispute, which would evidence visits made by intake coordinators to doctors and/or patients, failed to supply the Intermediary's auditors with job descriptions detailing the types of duties performed by intake coordinators or logs detailing the length of time spent performing those duties, and gave the Intermediary no method with which to apportion the intake coordinators' time between

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68 Provider Exhibit 13.

69 Id.

70 Id.

71 Provider Position Paper at 15.

72 Tr. II at 23.

73 Id. at 102.

74 Tr. I at 45.

75 Id. at 45, 79.

76 See High Tech Home Health, Inc., v. Ætna Life Ins. Co., PRRB Dec. No. 97-D9, November 22, 1996, Medicare & Medicaid Guide (CCH), ¶ 44,935, and High Tech Home Health, Inc. v. Ætna Life Ins. Co., PRRB Dec. No. 97-Dl0, November 22, 1996, Medicare & Medicaid Guide (CCH), ¶ 44,936.

patient care and non-patient care functions, the Intermediary's adjustment disallowing the entire compensation of the Provider's intake coordinators was proper.

ISSUE 10 - AUTO MILEAGE/ALLOWANCE EXPENSE

Facts:

Based on its review of the Provider's costs, the Intermediary adjusted $30,420 in "Auto mileage/Allowance expense," for allowances it deemed were not supported by Form 1099's, for company vehicle expenses which it deemed were not accurately supported by mileage logs, and for transactions for which no documentation was submitted.

PROVIDER'S CONTENTIONS:

The Provider contends the Intermediary adjusted a portion of its auto mileage/allowance expense in the amount of $4,320 for its failure to file IRS Form 1099s for its employees. [77] The Provider argues that it was fully audited by the IRS in 1992, including auto mileage, and the IRS did not identify any problems. The Provider maintains it used the same 1992 record keeping methodology to identify costs claimed in its 1993 cost report.

It is the Provider's position that the Intermediary is estopped from making an adjustment in the current year since both the IRS and the Intermediary are acting on behalf of the Government and neither one made an adjustment in 1992.[78] The Provider contends that the Intermediary would have reimbursed these costs if 1099s had been issued to the appropriate employees. The Provider contends that appropriate 1099s were issued. [79]

INTERMEDIARY'S CONTENTIONS:

The Intermediary adjusted $30,420 in auto Mileage/Allowance expense for allowances not supported by 1099's, for company vehicle expenses which were not accurately supported by mileage logs, and for transactions for which no documentation was submitted. The Intermediary points out that the Provider admitted in its Position Paper that the only mileage log it submitted to the Intermediary was, in the Provider's words, "totally lacking in shorter, daily mileage."[80]

The Intermediary explains that of the $30,420 in auto mileage/allowance expense which it disallowed, $4,320 was disallowed due to auto allowances paid to certain employees who did not receive 1099 forms. Although the Provider did eventually produce certain 1099's, the Provider failed to present any evidence which would tie these documents to the amount of the disallowance. [81]

The Intermediary also notes that although the Provider claimed it self-denied a portion of automobile expense due to its personal nature, the Provider failed to provide the Intermediary with sufficient documentation to support the business portion of the company vehicles. Because the Intermediary was left with no method to differentiate between reimbursable and non-reimbursable expenses, these expenses were also disallowed.

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77 Tr. II at 111.

78 Provider Post Hearing Brief at 28.

79 Provider Exhibit 35 at 101.

80 Provider Position Paper at 21, Provider Post Hearing Brief at 17..

81 See Provider Exhibit 8; Tr. II at 109.

The Intermediary rejects the Provider's argument that since the IRS conducted a complete audit of the Provider's mileage expense in 1993, the Intermediary is estopped from making this adjustment. However, it should be noted that while the IRS allows deductions for all ordinary and necessary expenses paid or incurred during the taxable year in the carrying on of a trade or business, the cost of travel incurred in connection with non-patient-care-related purposes is not allowable in computing Medicare reimbursement. HCFA Pub. 15-1 § 2102.3 Therefore, because there are two different standards involved, the IRS and the Intermediary are not estopped by the other's actions.

ISSUE 11 - STAFF TRAVEL/EDUCATION EXPENSE

Facts:

Staff travel/education costs were disallowed by the Intermediary because in its opinion either no documentation or inadequate documentation existed to support the Provider's claimed costs. The Intermediary's original adjustment of $6,270 was reduced by $836 as a result of additional documentation provided by the Provider. [82]

PROVIDER'S CONTENTIONS:

The Provider believes that it has provided adequate, although not perfect documentation, with some documentation for every cost.[83] The Provider contends that the Intermediary was unrealistic in the types of documentation it required the Provider to produce to document the travel costs. The Provider argues in its Post Hearing Brief that although it may not have had the exact documentation the Intermediary requested for the various expenses in this account, it produced alternative forms of documentation which the Intermediary should have relied upon. [84] The Provider also contends the Intermediary made adjustments for personal travel of the Provider without having any evidence to do so.

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends the Provider is mandated to demonstrate that all costs claimed on the cost report are reasonable, proper, necessary and related to patient care. Without documentation, the Intermediary disallowed these costs pursuant to 42 C.F.R. § 413.24 and HCFA Pub. 15-1
§ 2304. The Intermediary maintains it adjustments were based on missing invoices and on inadequate documentation to indicate how the expense related to the agency. [85]

ISSUE 12 - EDUCATION/OTHER EXPENSE

Facts:

The Intermediary made an adjustment of $23,338 to the Provider's education/other expense because the Intermediary determined that these expenses were not adequately documented ($7,914) and were disallowed as patient solicitation activities ($15,424).[86] The Provider did not provide any information in its post hearing brief or position paper contesting the $7,914.

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82 Provider Exhibit 28; Tr. II at 117.

83 Provider Post Hearing Brief at 29.

84 See Provider Post Hearing Brief at 29-30.

85 See Provider Exhibit 28; Intermediary Post Hearing Brief at 16-19.

86 Provider Exhibit 16.

PROVIDER'S CONTENTIONS:

The Provider asserts that the Intermediary assumes that its education expenses are solicitation expenses and is targeting them for denial. The Provider points out that physicians and their staff are generally unavailable except during lunch; hence, food expense is reimbursable as a cost of doing business, that is, for access. The Provider contends that the Intermediary's disallowance of the small amount it expends for physicians meals is illogical when compared to the cost of its medical denials. The Provider contends that with over 400 physicians referring to it, the cost of access, i.e. lunches, was $15,424 or less than $30 per physician and $10 per beneficiary. The Provider also points out that the Intermediary testified that it was the Provider's responsibility to educate the physicians. [87] The Provider contends that since the cost of medical denials exceeded the cost of education, it is clear that it should have been spending more on lunches to educate its physicians. [88]

INTERMEDIARY'S CONTENTIONS:

In support of its adjustment to the Provider's education/other expenses, the Intermediary points to HCFA Pub. 15-1 § 2113.2 which states:

> [v]isits made by HHA personnel to physicians to obtain referrals are considered patient solicitation. Any costs incurred for these activities are unallowable. These costs include . . . costs the HHA incurs for meals, entertainment, gifts, etc., given to influence these parties to refer patients to the HHA.

Id.

The Intermediary points out that although the Provider contends that the education/other expenses were incurred to educate physicians[89] and alleges it provided continuing education credits to physicians for attending these seminars, [90] the Provider failed to submit any documentation to support its assertions. [91] The Intermediary also points out that the attendance sheets were signed by one individual, not by the individual attendees. [92]

The Intermediary explains that the same type of expenses were noted in its FYE 12/31/92 audit of the Provider. At that time, the Intermediary contended that the Provider's owner, made the following admission:

> The director of nursing, intake coordinators and employees, having sufficient knowledge, used the Provider's listing of services available to go into the field and solicit doctor referrals and information about new doctors in the area to find doctors and educate them on the services performed by the Provider. Other educational services are performed also for the doctors already making referrals.

See Provider Exhibit 16.

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87 Provider Exhibit 21, pgs. 11-13.

88 See Provider Exhibit 14.

89 Tr. I at 76.

90 Id.

91 Tr. II at 93.

92 Id.

The Intermediary also points out that included in the adjustment for this issue are the costs of admission into Epcot Center and babysitting which the Provider submitted to the Intermediary under education/other expense. [93]

ISSUE 13 - MISCELLANEOUS EXPENSE

Facts:

The Intermediary made adjustments totaling $13,717 in this expense account. The adjustments were for costs not related to patient care, inadequate documentation, and an amount double posted to the cost report. [94] Except for the $11,656 in IRS penalties, the Provider did not contest the other miscellaneous adjustments.

PROVIDER'S CONTENTIONS:

The Provider contends the IRS penalty of $11,656 was caused by the failure of the Intermediary to properly and timely fund it. The Provider argues that lack of funding, as identified in its appeal of FYE 12/31/92, resulted in the lack of employee continuity because of inadequate cash to adequately pay Provider employees. As a result, an error was made in the IRS Form 941 payments which was not resolved for over four months. [95] Therefore, the Provider believes that since the resulting penalty was caused by the Intermediary, the expense should be allowable as an ordinary business expense. HCFA Pub. 15-1 § 2102.2.

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends it disallowed the IRS penalty amount because it was not related to patient care, and the Provider failed to present any evidence, in the form of live testimony or documentation, that it should be reimbursed for this expense. The Intermediary rejects the Provider's argument that the Intermediary should pay the penalty assessed by the IRS because the penalty was caused by the failure of the Intermediary to properly and timely fund the Provider. The Intermediary points out that the Board has ruled that the Provider's own mismanagement, not the Intermediary's actions, was the direct cause of the Provider's insufficient cash flow. [96] Therefore, the Intermediary maintains the Board should view the Provider's objections to the miscellaneous expense adjustments as either waived or barred by the doctrine of *res judicata*.

ISSUE 14 - BONUS EXPENSE

Facts:

In reviewing bonus expenses, the Intermediary found that $165,611 out of $214,520 had not been liquidated timely.[97] Therefore, the Intermediary disallowed this expense.

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93 Tr. II at 130-132; see also Intermediary Exhibit I-1.

94 Intermediary Exhibit I-2.

95 Provider Exhibit 32.

96 High Tech v. Ætna, PRRB Dec. No. 97-Dl0, November 22, 1996, Medicare & Medicaid Guide (CCH), ¶ 44,936. See Issue #3, Pt. No. 1 for Board references to Provider's insufficient cash flow.

97 Provider Exhibit 23.

PROVIDER'S CONTENTIONS:

The Provider contends the Intermediary's disallowance of its bonus expense is a continuation and direct result of the Intermediary's wrongful accounting practices.[98] The Provider argues that since the Intermediary failed to properly fund it, the Provider was unable to liquidate the bonus expense within one year.[99] The Provider rejects the Intermediary's position that a liability not liquidated within one year is unallowable. The Provider contends that the Intermediary's wrongful accounting practices void its obligation to liquidate this expense within one year.

The Provider explains that a portion of the disallowed amount was for intake coordinators' bonuses. The Provider argues that since intake coordinators expenses are allowable, the bonuses paid to them are allowable as an employee benefit.[100]

The Provider also points out that the Intermediary disallowed $5,236.56 of bonuses paid to contract employees.[101] It is the Provider's position that when a contract employee will work at inconvenient times like weekends and in inconvenient locations like high travel time rural areas, those employees deserve and require additional compensation in the form of bonuses so that they do the same good work in the future. The Provider also contends that a check for $2,576.20 was improperly excluded from the list and should be payable.

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that the Provider only submitted documentation to support $48,909 out of $214,520 in bonuses expenses.[102] The Intermediary also contends that there are no canceled checks or other forms of payment to document that the balance was ever paid out.[103] Therefore, the Intermediary disallowed this portion of the Provider's bonus expense.

The Intermediary points out that in the Provider's Position Paper, the Provider contended that if the intake coordinators' salaries were allowable, then bonuses paid to them should also be allowable as an employee benefit.[104] Accordingly, using the Provider's own logic, since the intake coordinators' salaries should be disallowed, their bonuses should also be disallowed.

ISSUE 15 - OWNER'S COMPENSATION

Facts:

For the fiscal period at issue, the Provider's owner held the position of Director of Nursing. In addition to her ownership interest in the Provider, the owner also had ownership interests in several other health-related organizations including, High Tech Staffing Services, Inc., Private Care, Inc., High Tech DME, Inc., and High Tech

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98 See High Tech v. Ætna, PRRB Dec. 97-D10 at Pg. 29.

99 Tr. II at 149.

100 Provider Post Hearing Brief at 33.

101 Provider Exhibit 23; Tr. I at 89; Tr. II at 146.

102 Provider Exhibit 23.

103 Tr. II at 143.

104 Provider Position Paper at 19.

Medical Billing, Inc.

The Intermediary disallowed $49,482 of the owner's salary based on its finding that the owner did not work full time for the Provider. At the hearing, the owner testified that she worked a minimum of 40 hours per week for the Provider and also received approximately $100,000 from her ownership interest in Private Care, Inc., although no work was performed for this business. [105]

PROVIDER'S CONTENTIONS:

The Provider argues that the Intermediary allocated less than one-half of the owner's time to the Provider although this owner held the position of Director of Nursing and there was no Assistant Director of Nursing for a 54,000 visit, and more importantly, a 1,557 beneficiary home health agency. (The Provider refers to the owner's compensation adjustment for FTE 12/31/92 in PRRB Dec. No. 97-D10. The Provider notes that the Board found in favor of the Provider regarding owner's compensation for the same issue as in the current case.) The Provider also points out that, although the owner's compensation claimed for 1994 was almost exactly the same as claimed in 1993, the Intermediary did not make an owner's compensation adjustment in the NPR issued on September 30, 1996 for FYE 12/31/94. See Provider Exhibit 9.

The Provider points out that the owner testified that as the Director of Nursing, she worked a minimum of 40 hours per week for High Tech Home Health, Inc. [106] The Provider contends that although the owner took a monthly draw from Private Care, Inc. totaling $100,000, for the sole purpose of spreading the income tax burden, there is no evidence of the owner performing services for Private Care, Inc. in FYE 12/31/93.

Finally, the Provider contends that since the Intermediary did not make an owner's compensation adjustment for the Director of Nursing in FYE 12/31/94, it is arbitrary and capricious and against the weight of the evidence to make such an adjustment for the current year.

INTERMEDIARY'S CONTENTIONS:

The Intermediary argues that the adjustment was made based on its finding that the owner, who was the Director of Nursing, did not work full-time for the Provider. [107] The Intermediary contends that the owner received $100,000 in salary and an auto allowance from Private Care, Inc. The Intermediary reasons that the owner was performing services for Private Care in order to receive this salary and auto allowance. The Intermediary believes that the fact that some of the organizations owned by the Provider's owner were physically located in the same building as the Provider is further evidence that the owner performed services for these other organizations in addition to the services she performed for the Provider. [108]

During FYE 12/31/93, the Provider sought to be reimbursed $107,610 for the owner's salary. The Intermediary points out that it did not raise the question as to whether the salary should be adjusted because it was not "reasonable owner's compensation." Rather, the Intermediary completed a comparison of the owner's salary based upon the percent of time the owner worked at Private Care, Inc., and the percent of time she worked at the

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105 Tr. I at 31.

106 Id.

107 Intermediary Post Hearing Brief at 22.

108 Tr. II at 157; Provider Exhibit 11.

Provider.[109] Based upon the Intermediary's calculations, the Intermediary allocated $58,128 of owner's compensation to the Provider, and disallowed the remaining $49,482 in salary as compensation earned for work performed at an entity other than the Provider.

The Intermediary's brief includes a discussion of various reasons it felt justified in apportioning the owner's salary between the Provider and the owner's other businesses. [110]

The Intermediary refers to the Board's decision of the Provider's FYE 1992 appeal, (PRRB Dec. No. 97-D10), in which the Board found that the Intermediary's adjustment to owner's compensation was improper. The Board reasoned that because the Intermediary offered no convincing evidence to refute the owner's testimony, the Board would accept the owner's testimony as true.

It is the Intermediary's position, however, that it is not its burden to offer evidence establishing that the owner was compensated improperly, but the Provider's burden to offer evidence upon which the Intermediary can rely on in calculating the Provider's reimbursement from the Medicare program. The Intermediary argues that entitlement to reimbursement from the Medicare program is not assumed, but must be established by the party requesting reimbursement. Medicare regulations clearly state that providers have the burden to furnish intermediaries with adequate cost data. 42 C.F.R. § 413.24(a) These regulations define "adequate cost data" as information which is accurate, in sufficient detail, capable of being audited, and maintained in a manner consistent from one period to another. 42 C.F.R. § 413.24(c) The Intermediary maintains that a provider should not be able to shift its burden of proof simply by furnishing its intermediary with information which is inaccurate, insufficient in detail, and maintained in such an inconsistent manner from one period to another that it is incapable of being audited. [111]

The Intermediary further contends that as in the previous year's appeal, (FYE 12/31/92), the Provider failed to submit any documentary evidence to support its contention that its owner worked full time. Rather, the only evidence which the Provider offered, to prove that the owner worked full time for the Provider, was the owner's testimony. Without any documentary evidence to support the Provider's contention, the Intermediary asserts that the Provider is implicitly requesting the Board take the owner's testimony as true.

ISSUE 16 - OVERHEAD EXPENSE

Facts:

The Intermediary established a non-reimbursable cost center on the Provider's cost report to include the costs of another business owned by the Provider, High Tech DME. The Intermediary determined that High Tech DME was not operating as an independent company in FYE 12/31/93, and was in fact dependent on the Provider for its operation.

PROVIDER'S CONTENTIONS:

The Provider alleges the Intermediary committed fraud by the inclusion of $208,071 of High Tech DME, Inc.'s expenses in a nonreimbursable cost center on the Provider's cost report which caused the disallowance of $175,602

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109 Provider Exhibit 11.

110 See Intermediary Post Hearing Brief at 32-35.

111 See Holy Name of Jesus Hospital v. Blue Cross/Blue Shield Association and Blue Cross/Blue Shield of Alabama, HCFA Deputy Admin. Dec., September 6, 1984, Medicare & Medicaid Guide (CCH) at ¶ 34,139.

in overhead expenses.[112]

The Provider asserts that the disallowance was based on the Intermediary's belief that High Tech DME lacked the management personnel to run this company, hence, it was being run by Provider personnel. The Provider explains that in 1992 and early in 1993, High Tech DME was effectively a virtual company and it wasn't until late in 1993 that it had independent personnel. The Provider points out that one half of High Tech DME's payroll expense was generated in the last quarter of FYE 12/31/93. Therefore, the Provider rejects that Intermediary's position that because the DME company had low personnel costs, then it must have been operated by the Provider.

The Provider also points out that the Intermediary made a significant owner's compensation adjustment, alleging that the Provider's owner did not work full time for the Provider. See Issue 15 above. The Provider contends that if any part of the owner's compensation adjustment stands, then the collapse of High Tech DME into the Provider's cost report is improper and illogical and must be reversed.[113]

The Provider also contends that the Intermediary's auditor admitted a lack of knowledge of the DME business and because of this, the establishment of a non-reimbursable cost center for the DME company was improper. The Provider also notes that the Intermediary failed to collapse the DME company into the Provider in either FYE 12/31/92 or FYE 12/31/94.

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that High Tech DME, Inc. should be represented on the Provider's cost report as a non-reimbursable cost center for the proper allocation of A & G costs. The Intermediary contends its adjustment was in accordance with 42 C.F.R. § 413.24 and HCFA Pub 15-1 § 2328.[114]

The Intermediary maintains that it adjusted the Provider's overhead expense to allow proper allocation of administrative and general costs. Specifically, this adjustment concerns the inclusion of High Tech DME on the Provider's Medicare cost report for overhead allocation purposes. The Intermediary points out that High Tech DME is located in a small suite upstairs from the Provider.[115] While High Tech DME's suite included a couple of small offices and little, if any, office equipment, the Provider's suite included a reception area, a copy machine, a separate telephone system, a kitchen, and a restroom.[116] The Intermediary points out that the owner of both the Provider and High Tech DME, admitted that the two companies operated in conjunction with each other so that when a patient needed both home care and equipment, the patient could receive complete service from one place.[117] The Intermediary also notes that there was other testimony from the Provider's owner at the hearing which indicated that the two companies were treated as one.[118] The Intermediary acknowledges that there is convincing evidence that High Tech DME was an independently operated organization in 1994, but in 1993, it was dependent upon the

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112 Provider Post Hearing Brief at 36.

113 Id. at 38.

114 Intermediary Proposed Decision at 8.

115 Provider Exhibit 11; Tr. I at 52-54.

116 Id.

117 Tr. I at 58.

118 See Tr. I at 69-70.

Provider.[119] Since High Tech DME could not be considered an independently operated organization in 1993, the Intermediary included High Tech DME, Inc. as a non-reimbursable cost center on the cost report for FYE 12/31/93.

CITATION OF THE LAW, REGULATIONS AND PROGRAM INSTRUCTIONS :

1. Regulations - 42 C.F.R.:

§ 405.1835-.1841.	-	Board Jurisdiction
§ 413.9 et seq.	-	Cost Related to Patient Care
§ 413.20	-	Financial Data and Reports
§ 413.24	-	Adequate Cost Data

2. Program Instructions-Provider Reimbursement Manual (HCFA Pub. 15-1) :

§ 906.4	-	Unpaid Compensation
§ 2102 et seq.	-	Costs Related to Patient Care
§ 2113 et seq.	-	Home Health Coordination (or Home Care Intake Coordination) Costs
§ 2122.2	-	Taxes not Allowable as Costs
§ 2136.1	-	Allowable Advertising Costs
§ 2140.3	-	Deferred Compensation-Formal Plan
§ 2304	-	Adequacy of Cost Information
§ 2305 et seq.	-	Liquidation of Liabilities
§ 2328	-	Distribution of General Service Costs to Nonallowable Cost Areas

3. Case Law:

High Tech Home Health, Inc, v. Ætna Life Ins, Co. , PRRB Dec. No. 97-D9, November 22, 1996, Medicare & Medicaid Guide (CCH) ¶ 44,935; HCFA Adm. Declined Rev., January 7, 1997.

High Tech Home Health, Inc, v. Ætna Life Ins, Co. , PRRB Dec. No. 97-Dl0, November 22, 1996, Medicare & Medicaid Guide (CCH) ¶ 44,936, HCFA Adm. Declined Rev., January 7, 1997.

In Home Health v. Blue Cross and Blue Shield of Iowa , PRRB Dec. No. 96-D36, June 10, 1996, Medicare & Medicaid Guide (CCH) ¶ 44,477, rev'd HCFA Admin., August 4, 1996, Medicare & Medicaid Guide (CCH) ¶ 44,594.

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119 See Intermediary Post Hearing Brief at 25-26; Tr. II at 171-172.

In Home Health v. Donna Shalala, Federal District Court, District of Minnesota, Third Division, Civil Case No. 3-94-CV- 1504 RHK/FLN.

VNA of Greater St. Louis, St. Louis, Missouri v. Blue Cross Health Services, Inc., of St Louis, Missouri, PRRB Dec. No. 86-D47, December 31, 1985, Medicare & Medicaid Guide (CCH) ¶ 35,467 (1985) HCFA Admin. Declined Rev., February 20, 1986.

Holy Name of Jesus Hospital v. Blue Cross/Blue Shield Association and Blue Cross/Blue Shield of Alabama, HCFA Deputy Admin. Dec., September 6, 1984, Medicare & Medicaid Guide (CCH), ¶ 34,139.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION :

ISSUE - 1 EMPLOYEE SALARY AND BENEFITS

The Board finds that the Intermediary's adjustment disallowing 100 percent of the salary and benefits for one of the Provider's home health aide coordinators was proper. The Board finds the Provider did not adhere to the regulations at 42 C.F.R. § 413.24 by failing to keep adequate records to substantiate this employee's work status at the Provider. The Board disagrees with the Provider's contention that the Intermediary's adjustment was based entirely on a letter which indicated the employee worked for 2 days during the year at a non-Provider business.

The Board finds the employee in question was not a full time employee. This was evidenced by three different W-2 forms (other than the Provider) for the employee which demonstrates to the Board that this employee also worked for other non-Provider entities. See Provider Exhibit 19.

The Board also considered the program integrity referral statement that indicated this employee was working a substantial amount of time per week in a physician's office. See Provider Exhibit 17.

In summary, the Board concludes that since the evidence supports the Intermediary's finding that the employee was not a full time Provider employee, the Provider was required to document the employee's status with the Provider, which it did not do. Accordingly, the Board considers the Intermediary's adjustment appropriate.

ISSUE 2 - ADVERTISING

The Board finds the Intermediary's adjustment to disallow advertising costs because they were promotional in nature was improper. After reviewing the advertisement, the Board disagrees with the Intermediary that it was solely for soliciting referrals and was therefore promotional in nature. See Provider Exhibit 33. Instead, the Board finds the Provider's placement of an ad in a medical society's publication to appraise physicians of the availability of the Provider's services was reasonable as described in 42 C.F.R. § 413.9(c)(3) and HCFA Pub. 15-1 § 2136.1.

ISSUE 3 - DEFERRED COMPENSATION

The Board finds that the Intermediary's adjustment disallowing an accrual for a deferred compensation plan covering its owners, because it did not meet the requirements of a deferred compensation plan as required by HCFA Pub. 15-1 § 2140.3, was proper. The Board notes that in order for the plan to be properly funded, it must state the requirements for vesting and provide a basis for computation of the benefits to be paid. The Board did not find any evidence in the record that this was done by the Provider.

The Board also finds that the note for the deferred compensation was never liquidated within 75 days after the end of the cost reporting period as required by HCFA Pub. 15-1 §§ 2305.2 and 906.4. Additionally, the Board did not find convincing evidence in the record to support the Provider's contention that the Intermediary deliberately under funded it in the current year, hence giving the Provider a reason not to liquidate the expense timely.

ISSUE 4 - PAYROLL BENEFITS/PROFIT SHARING

The Board finds that the Intermediary's adjustment disallowing a portion of the Provider's profit sharing expense was proper. The Board notes that the Provider did not provide any evidence to support its contention that the amount was a 1993 expense. The Board does not dispute that the amount in question, $1,703, was a Provider expense, however, lacking documentation to support it as a 1993 expense, the Board concludes it was a 1994 expense. The Board notes if the Provider had adequate supporting documentation for the amount, the 1994 cost report could have been reopened to claim this expense.

ISSUE 5 - DUES AND SUBSCRIPTION EXPENSE

The Board finds that the Intermediary's adjustment disallowing $79 for a subscription to *Business Week* was improper. The Board concludes that the subscription cost could be considered an ordinary business expense in operating a home health care agency. The Board disagrees with the Intermediary's assertion that it should be disallowed because the invoice was made out to the owner instead of the Provider's official name.

The Board also finds that the Intermediary's adjustment disallowing $115 in dues and subscription costs for lack of supporting documentation was proper. The Board notes that the Provider did not provide testimony or documentation at the hearing to substantiate this amount.

ISSUE 6 - AUTO INSURANCE AND LEASE EXPENSE

The Board finds that the Intermediary's adjustment disallowing auto insurance and auto lease expense for lack of supporting documentation was proper in accordance with 42 C.F.R. § 413.24 and HCFA Pub. 15-1 § 2304. The Board feels strongly that supporting documentation must exist to support expenses claimed on the cost report. The Board finds that the Provider did not make an adequate case at the hearing, in its position paper or in its post hearing brief to support these costs. The Board concludes that since the Provider did not provide convincing evidence either in the form of testimony or documentation to support the costs, the Intermediary was justified in disallowing the costs.

ISSUE 7 - LIABILITY INSURANCE

The Board finds that the Intermediary's adjustment disallowing a portion of the liability expense claimed by the Provider was proper in accordance with 42 C.F.R.§ 413.24 and HCFA Pub. 15-1
§ 2304. As noted above in Issue 6, the Board feels strongly that supporting documentation must exist to support expenses claimed on the cost report. The Board finds that the Provider did not provide adequate supporting documentation to substantiate that the entire $23,204 in liability insurance costs was related solely to Provider operations. The Board notes the Provider attempted to support this cost through a letter from its insurance agent, however, the Board agrees with the Intermediary that this was inadequate to support the entire amount claimed by the Provider. The Board finds the Intermediary's method of allocating the costs, based on accumulated costs in the various Provider owned businesses, was acceptable in lieu of other documentation to support the costs.

ISSUE 8 - PROFESSIONAL ACCOUNTING EXPENSE

The Board finds the Intermediary's adjustment disallowing three components of the Provider's professional accounting expense was proper in accordance with 42 C.F.R. §§ 413.9 and 413.24.
Regarding the Intermediary's first adjustment on this issue, in which it disallowed $24,500 for accruals not supported by documentation, the Board finds that $20,000 of this amount was an "anticipated" expense in 1993 for a

possible legal cost in a future year.[120] The Board finds there was no evidence in the form of an invoice in 1993 to support this cost. The Board finds that such expenses are allowable if documentation exists. The Board notes that the Provider did not dispute the remaining $4,500 of the first component of this adjustment.

Regarding the second component of this adjustment, $2,490 for legal expenses related to a trademark, the Board finds this particular expense was not related to patient care at the Provider. The Board concludes that based on testimony and evidence submitted, the cost was related to a non-Provider entity. The Board notes that although this type of cost may be allowable in some instances, because it was related to a non-Provider entity, it is unallowable in the current case.

Finally, the Board agrees with the Intermediary's rationale for disallowing $7,775 in accounting services expenses. The Board finds that if adequate supporting documentation existed for these expenses, the Provider could have requested reopening of the 1994 cost report to claim these costs.

ISSUE 9 - INTAKE COORDINATORS SALARIES AND BENEFITS

The Board finds the Intermediary's adjustment disallowing 100 percent of the compensation claimed by the Provider for its intake coordinators was proper in accordance with the regulations at 42 C.F.R. §§ 413.9 and 413.24. The Board finds that the intake coordinators were performing other than intake coordinator work as evidenced by the activity records in Provider Exhibit 13. After reviewing the record, it is unclear to the Board as to the complete list of functions being performed by the intake coordinators.

In addition, the Board finds there was no evidence to support that the intake coordinators activities contained in the job descriptions were actually being performed. Lacking concrete evidence on the amount of time spent by the intake coordinators performing various activities, the Intermediary was left with no method with which to apportion the intake coordinators costs between patient care and non-patient care functions. Accordingly, since the Intermediary was left with no method by which to apportion time, the Board finds the Intermediary's adjustment disallowing the entire compensation of the Provider's intake coordinators was proper.

ISSUE 10 - AUTO MILEAGE ALLOWANCE EXPENSE

The Board finds that the Intermediary's adjustment disallowing $30,420 in auto mileage allowances was proper in accordance with the regulations at 42 C.F.R. §§ 413.9 and 413.24. The Board finds the Intermediary's adjustment was based on several reasons including 1) amounts for which no Form 1099s were issued to contract employees to support some costs and 2) other compensation that was not supported by adequate documentation in the form of mileage logs to substantiate the vehicles were being used for patient care. More importantly, however, the Board notes that the majority of disallowed costs, $22,984, were disallowed because there was no documentation whatsoever to demonstrate how these costs related to anything in this expense account. See Provider Exhibit 26.

The Board does not agree with the Provider's argument that the adjustment is solely related to its failure to file Form 1099s. Rather, as stated above, there were $22,984 in claimed costs that did not relate to anything in this account, and the Provider did not try to defend this amount at the hearing or in its briefs. For the balance of the expenses in this account, the Board finds there simply was not enough documentation in the record to indicate how the costs were related to patient care.

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120 Provider Post Hearing Brief at 20.

ISSUE 11 - STAFF TRAVEL EDUCATION EXPENSE

The Board finds that the Intermediary's adjustment disallowing staff travel education expense for lack of supporting documentation was proper in accordance with 42 C.F.R. § 413.24 and HCFA Pub. 15-1 § 2304. [121] As noted above in several other issues in this case, the Board feels strongly that supporting documentation must exist to support expenses claimed on the cost report. In this issue, the Intermediary disallowed costs that the Provider had classified as lodging and airfare costs related to patient care. The Provider claimed it had provided adequate, although not perfect documentation to support these costs. The Board was unpersuaded by the Provider's attempt to justify these costs in its position paper or in its post hearing brief, and finds that the Provider did not make an adequate case at the hearing.

In fact, after reviewing the record, the Board finds that in addition to lacking the proper documentation to even substantiate these costs, some of the items claimed by the Provider were questionable as to being related to patient care. 42 C.F.R. § 413.9 The Board concludes that since the Provider did not provide convincing evidence either in the form of testimony or documentation to support the costs, the Intermediary was justified in disallowing the costs.

ISSUE 12 - EDUCATION/OTHER EXPENSE

The Board finds the Intermediary's adjustment disallowing "education/other" expense was proper. In making this determination, the Board was persuaded by the Intermediary's argument that intake coordinators, by giving education seminars to physicians, while providing free lunches, were performing non-reimbursable solicitation activities described in the program instructions. HCFA Pub. 15-1 § 2113.2, states in part:

> [v]isits made by HHA personnel to physicians to obtain referrals are considered patient solicitation. Any costs incurred for these activities are unallowable. These costs include . . . costs the HHA incurs for meals, entertainment, gifts, etc., given to influence these parties to refer patients to the HHA.

Id. (emphasis added.)

The Board was also persuaded by the fact that there were no rosters of the seminars signed by the individual physicians or documentation in the record to support the course content. Therefore, the Board was unable to make a determination that the costs incurred in the issue were in fact legitimate costs related to patient care. The Board notes that $15,424 of the $23,338 that the Intermediary disallowed was related to lunches at the seminars. The remaining $7,914 was disallowed by the Intermediary for lack of supporting documentation. [122] The Provider did not provide evidence in the form of testimony at the hearing or documentation in its post hearing brief to support this amount. Accordingly, the Board finds that the Intermediary was also justified in disallowing the "non-lunch" portion of the adjustment for lack of supporting documentation.

ISSUE 13 - MISCELLANEOUS EXPENSE

The Board finds that the Intermediary's adjustment disallowing $13,717 in miscellaneous expenses that lacked supporting documentation and/or were not related to patient care was proper. A major portion of the adjustment was $11,656 for an IRS penalty which the Provider contends was caused by the Intermediary and

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[121] During the discovery phase of this case, the Provider submitted documentation to support $836.10 of the adjustment. The Intermediary agreed to allow these costs. See Tr. II at 117.

[122] Provider Exhibit 16.

therefore should be allowable. The Board disagrees. According to Program instructions, at HCFA Pub. 15-1 § 2122.2:

> [c]ertain taxes which are levied on providers are non-allowable costs. These taxes are:
>
> A. Federal Income and excess profit taxes, including any interest or penalties paid thereon.

Id. (emphasis added.)

Based on the above Program instruction, the Board concludes that the IRS penalty amount claimed by the Provider was unallowable. The Board also notes that the Provider did not contest the remainder of the adjustment. Therefore, the Board finds the Intermediary was justified in disallowing the $13,717 in miscellaneous expenses claimed by the Provider.

ISSUE 14 - BONUS EXPENSE

The Board finds that the Intermediary's adjustment disallowing bonus expenses because they had not been liquidated timely was proper. The Intermediary properly adhered to HCFA Pub. 15-1 § 2305, which requires that short term liabilities be liquidated within one year, as the basis for its adjustment.

The Board rejects the Provider's argument that since the Intermediary failed to properly fund it, the Provider was unable to liquidate the bonus expense within one year. The Board finds there is no evidence in the record to support the Provider's contention. The Board was persuaded by the Intermediary's argument that there was no documentation in the form of canceled checks or other forms of payment to substantiate that the bonuses disallowed had ever been paid out. The Board also notes that in Issue 9 above, it concluded that the salaries and benefits of the Provider's intake coordinators were unallowable. As a significant portion of the amounts disallowed were bonuses for intake coordinators,[123] then the bonuses associated with intake coordinators are also unallowable.

ISSUE 15 - OWNER'S COMPENSATION

The Board finds the Intermediary's adjustment to disallow owner's compensation was improper. Rather, the owner's compensation was reasonable as described by the regulations at 42 C.F.R. § 413.9. In making this finding, the Board opines that the determinative issue is not whether the owner's compensation was excessive, but rather whether the owner's salary should be apportioned to related entities.

The Board finds insufficient evidence in the record to indicate that the owner's salary was excessive for a full time director of nursing. The Intermediary's arguments center around its contention that since the owner received compensation from a related organization, the owner could not have worked full time at the Provider. The Board finds that there is no evidence in the record to indicate that the Intermediary was contesting the qualifications of the owner to perform as a director of nursing. Upon examination, the Board is persuaded that those qualifications were more than sufficient to perform the functions detailed in the Director of Nursing job description. [124] Accordingly, the Board concludes that the amount of compensation was not excessive. The only remaining matter the Board must decide is whether the owner's compensation should be apportioned to related organizations.

The Board finds that the owner worked full time for the Provider. Evidence in record does not support the Intermediary's allegation that the owner performed services for related entities, namely Private Care, Inc. The thrust of the Intermediary's argument was that because the owner received $100,000 in compensation and an auto allowance from Private Care, Inc., and because some of the organizations owned by the Provider were in the same

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123 Provider Post Hearing Brief at 33.

124 Provider Exhibit 11.

building as the Provider, the owner did not work full time for the Provider. [125] However, the Board opines that this fact is not, in and of itself concrete evidence for it to render a decision. The Board places great weight on the testimony of the owner in which she stated that she did not perform any services for the $100,000 she received from Private Care, Inc., and that she worked a minimum of 40 hours a week for the Provider. [126] Without convincing evidence to the contrary, the Board is persuaded by the owner's testimony.

In conclusion, the Board finds that 1) there is no evidence or arguments in the record challenging the amount the owner received as being excessive for a full time director of nursing, 2) the owner's testimony that she worked full time for the Provider was persuasive, and 3) the Intermediary offered no convincing evidence to refute the owner's testimony. Therefore, the Board finds the Intermediary's adjustment disallowing owner's compensation was improper.

ISSUE 16 - OVERHEAD EXPENSE

The Board finds that the Intermediary's adjustment to establish a non-reimbursable cost center on the Provider's cost report to properly distribute general and administrative expenses was proper in accordance with the regulation and program instructions at 42 C.F.R. § 413.24 and HCFA Pub. 15-1 § 2328 respectively. The Board was persuaded by the Intermediary's argument and analysis that High Tech DME, which was owned by the Provider, should be represented as a non-reimbursable cost center for the proper allocation of administrative and general costs.

Specifically, the Board was persuaded by the testimony which established that High Tech DME and the Provider were housed in the same building and that the two companies shared administrative items such as a reception area, telephone system, kitchen and restroom. [127] There was also testimony from the Provider's owner that funds were transferred between the companies to keep current on payroll taxes. [128] The Board was further persuaded that High Tech DME was not operating as a independent company based on the Intermediary's analysis of High Tech DME's salaries and revenue in 1993 and 1994. [129] Based on this analysis, the Board concludes that High Tech DME was receiving general and administrative support from the Provider during 1993.

Based on the evidence, the Board concludes that High Tech DME, which was housed in the same building as the Provider, was dependent on the Provider during 1993 for administrative support. Accordingly, the establishment of a non-reimbursable cost center to properly allocate general and administrative expenses to High Tech DME was proper.

DECISION AND ORDER:

ISSUE 1 - EMPLOYEE SALARY AND BENEFITS

The Intermediary's disallowance of the employee's salaries and benefits in this adjustment was proper. The Intermediary's adjustment is affirmed.

ISSUE 2 - ADVERTISING

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125 Provider Exhibit 11; Tr. II at 157.

126 Tr. I at 31.

127 Tr. I at 52-54; Provider Exhibit 11; Intermediary Post Hearing Brief at 24-25.

128 Tr. I at 69-70.

129 Intermediary Post Hearing Brief at 25-26; Tr. II at 172.

The Intermediary's adjustment disallowing advertising costs was improper. The Intermediary's adjustment is reversed.

ISSUE 3 - DEFERRED COMPENSATION EXPENSE

The Intermediary's disallowance of deferred compensation was proper. The Intermediary's adjustment is affirmed.

ISSUE 4 - PAYROLL BENEFITS/PROFIT SHARING

The Intermediary's adjustment disallowing payroll benefits/profit sharing expense was proper. The Intermediary's adjustment is affirmed.

ISSUE 5 - DUES AND SUBSCRIPTION EXPENSE

The Intermediary's adjustment disallowing $194 in dues and subscription expense is modified. The Board reverses $79 of the Intermediary's adjustment and affirms $115 of the adjustment.

ISSUE 6 - AUTO INSURANCE AND LEASE EXPENSE

The Intermediary's adjustment disallowing auto insurance and lease expense was proper. The Intermediary's adjustment is affirmed.

ISSUE 7 - LIABILITY INSURANCE EXPENSE

The Intermediary's adjustment disallowing a portion of the liability insurance claimed by the Provider was proper. The Intermediary's adjustment is affirmed.

ISSUE 8 - PROFESSIONAL ACCOUNTING EXPENSE

The Intermediary's adjustment disallowing professional accounting expense was proper. The Intermediary's adjustment is affirmed.

ISSUE 9 - INTAKE COORDINATORS' SALARIES AND BENEFITS

The Intermediary's adjustment disallowing intake coordinators' salaries and benefits for lack of adequate supporting documentation was proper. The Intermediary's adjustment is affirmed.

ISSUE 10 - AUTO MILEAGE/ALLOWANCE EXPENSE

The Intermediary's adjustment disallowing auto mileage allowances for lack of adequate supporting documentation was proper. The Intermediary's adjustment is affirmed.

ISSUE 11 - STAFF TRAVEL EDUCATION EXPENSE

The Intermediary's adjustment disallowing staff travel/education expense for lack of supporting documentation was proper. The Intermediary's adjustment is affirmed.

ISSUE 12 - EDUCATION OTHER/OTHER EXPENSE

The Intermediary properly determined that expenses claimed by the Provider in this account were either undocumented or related to solicitation activities. The Intermediary's adjustment is affirmed.

ISSUE 13 - MISCELLANEOUS EXPENSE

The Intermediary properly determined that expenses claimed by the Provider in this account were either undocumented or unrelated to patient care, i.e. IRS penalty. The Intermediary's adjustment is affirmed.

ISSUE 14 - BONUS EXPENSE

The Intermediary properly disallowed bonuses expenses because they had not been liquidated timely. The Intermediary's adjustment is affirmed.

ISSUE 15 - OWNER'S COMPENSATION

The Intermediary's disallowance of owner's compensation was improper. The Intermediary's adjustment is reversed.

ISSUE 16 - OVERHEAD EXPENSE

The Intermediary's adjustment of overhead expenses by the establishment a non-reimbursable cost center on the Provider's cost report was proper. The Intermediary's adjustment is affirmed.

Board Members Participating:

Irvin W. Kues
James G. Sleep
Henry C. Wessman, Esq.
Martin W. Hoover, Jr., Esq.
Charles R. Barker

Date of Decision: October 29, 1998

FOR THE BOARD:

Irvin W. Kues
Chairman