APPENDIX

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APPENDIX A

THE SUPREME COURT OF OHIO

Case No. 2020-1471

[Filed: February 16, 2021]

CHS-Lake Erie, Inc. et al	)
	)
v.	)
	)
Ohio Department of Medicaid	)
	)

ENTRY

Upon consideration of the jurisdictional memoranda filed in this case, the court declines to accept jurisdiction of the appeal pursuant to S.Ct.Prac.R. 7.08(B)(4).

(Franklin County Court of Appeals; No. 18AP-897)

/s/ Maureen O'Connor
Maureen O'Connor
Chief Justice

The Official Case Announcement can be found at http://www.supremecourt.ohio.gov/ROD/docs/

APPENDIX B

IN THE COURT OF APPEALS OF OHIO
TENTH APPELLATE DISTRICT

No. 18AP-897
(C.P.C. No. 16CV-9766)

(REGULAR CALENDAR)

[Filed: October 22, 2020]

CHS-Lake Erie, Inc. et al.,	)
	)
Appellants-Appellees/ Cross-Appellants,	)
	)
v.	)
	)
Ohio Department of Medicaid,	)
	)
Appellee-Appellant/ Cross-Appellee.	)
	)

MEMORANDUM DECISION

Rendered on October 22, 2020

On brief: *Webster* & *Associates, Co., LPA,* and *Geoffrey E. Webster,* for appellees/cross-appellants.

On brief: *Dave Yost,* Attorney General, and *Rebecca L. Thomas,* for appellant/cross-appellee.

ON APPLICATION FOR RECONSIDERATION
ON APPLICATION FOR CONSIDERATION
EN BANC ON MOTIONS

BEATTY BLUNT, J.

{¶ 1} Appellants-appellees/cross-appellants, CHS-Glenwell, Inc. (dba Glen Meadows), CHS-Glenwell, Inc. (dba Wellington Manor), CHS-Greater Cincinnati, Inc. (dba East Galbraith Health Care Center), CHS-Lake Erie, Inc. (dba Carington Park), CHS-Miami Valley, Inc. (dba Vandalia Park), CHS-Miami Valley, Inc. (dba Franklin Ridge), and CHS-Ohio Valley, Inc. (dba Terrace View Gardens) (collectively, "CHS") have filed timely applications seeking reconsideration, pursuant to App.R. 26(A)(1), and consideration en banc, pursuant to App.R. 26(A)(2), of this court's decision in *CHS-Lake Erie, Inc. v. Ohio Dept. of Medicaid,* 10th Dist. No. 18AP-897, 2020-Ohio-505. Appellee-appellant/cross-appellee, the Ohio Department of Medicaid (the "department"), opposes CHS's applications. For the reasons which follow, we deny CHS's applications for reconsideration and consideration en banc.

I. Procedural Matters: CHS's Motion to Convert and Motion to Exceed Page Limitation Granted

{¶ 2} Initially, we must resolve two pending motions concerning CHS's post-decision filings. This court rendered its decision in *CHS-Lake Erie* on February 13, 2020 and issued the judgment entry corresponding to the decision on February 18, 2020. On

February 24, 2020, CHS filed a combined application for reconsideration and consideration en banc and a separate motion to certify a conflict. Although CHS's combined application for reconsideration and consideration en banc contained an argument to support CHS's request for reconsideration, CHS did not present an argument to support its request for consideration en banc. CHS's motion to certify a conflict asserted that our decision in *CHS-Lake Erie* conflicted with the following two decisions rendered by this court: *Meadowbrook Care Ctr. v. Ohio Dept. of Job & Family Servs.,* 10th Dist. No. 06AP-871, 2007-Ohio-6534, and *OMG MSTR LSCO, LLC v. Ohio Dept. of Medicaid,* 10th Dist. No. 18AP-223, 2018-Ohio-4843.

{¶ 3} On March 5, 2020, the department filed memoranda in opposition to CHS's motion to certify a conflict and CHS's combined application for reconsideration and consideration en banc. The department asserted this court should deny CHS's motion to certify a conflict as CHS failed to allege a conflict between *CHS-Lake Erie* and a decision from another court of appeals of this state. Although the department noted that CHS failed to present an argument to support its request for consideration en banc, the department also asserted there was no conflict of law between *CHS-Lake Erie* and either *Meadowbrook Care Ctr.* or *OMG MSTR LSCO, LLC.*

{¶ 4} On March 10, 2020, CHS filed a combined motion asking this court to convert its motion to certify a conflict to an application for consideration en banc and for leave to file an over length application for consideration en banc instanter. CHS acknowledged

the alleged "conflict in the holdings does indeed exist within the Tenth Appellate District as opposed to a conflict in opinions issued by different districts," and asserted the arguments contained in its motion to certify a conflict "would have been appropriately contained in an application for en banc consideration." (Appellees/Cross-Appellants' Mot. to Convert at 3.)

{¶ 5} To certify a conflict between cases, "the certifying court must find that its judgment is in conflict with the judgment of a court of appeals of another district." *Whitelock v. Gilbane Bldg. Co.,* 66 Ohio St.3d 594, 596 (1993). *Accord* App.R. 25(A). The "procedure for certified conflicts does not apply to conflicts existing within an appellate district." *In re J.J.,* 111 Ohio St.3d 205, 2006-Ohio-5484, paragraph three of the syllabus. As CHS never asserted the judgment in *CHS-Lake Erie* conflicted with the judgment of a court of appeals of another district, CHS never even raised a potential issue for certification. In contrast, the purpose of an en banc proceeding is to resolve conflicts of law that arise within an appellate district. App.R. 26(A)(2)(a); *McFadden v. Cleveland State Univ.,* 120 Ohio St.3d 54, 2008-Ohio-4914, ¶ 10, 15-16.

{¶ 6} Accordingly, in the interests of justice, we grant CHS's motion to convert its motion to certify a conflict to an application for consideration en banc and find that CHS has withdrawn its motion to certify a conflict. We also grant CHS's motion for leave to exceed the page limitation on its application for consideration en banc.

II. Application for Reconsideration Denied

{¶ 7} When presented with an application for reconsideration filed pursuant to App.R. 26, an appellate court must determine whether the application "calls to the attention of the court an obvious error in its decision, or raises an issue for consideration that was either not considered at all or was not fully considered by the court when it should have been." *Columbus v. Hodge,* 37 Ohio App.3d 68 (10th Dist.1987), paragraph one of the syllabus. "'App.R. 26 provides a mechanism by which a party may prevent miscarriages of justice that could arise when an appellate court makes an obvious error or renders an unsupportable decision under the law.'" *Huff v. Ohio State Racing Comm.,* 10th Dist. No. 15AP-586, 2017-Ohio-948, ¶ 2, quoting *State v. Owens,* 112 Ohio App.3d 334, 336 (11th Dist.1996).

{¶ 8} However, an appellate court will not grant "[a]n application for reconsideration * * * just because a party disagrees with the logic or conclusions of the appellate court." *Bae v. Dragoo & Assocs., Inc.,* 10th Dist. No. 03AP-254, 2004-Ohio-1297, ¶ 2. "Furthermore, an application for reconsideration is not a means to raise new arguments or issues." *Electronic Classroom of Tomorrow v. State Bd. of Edn.,* 10th Dist. No. 17AP-767, 2019-Ohio-1540, ¶ 3, citing *State v. Wellington,* 7th Dist. No. 14 MA 115, 2015-Ohio-2095, ¶ 9.

{¶ 9} In *CHS-Lake Erie,* this court addressed the department's appeal and CHS's cross-appeal from the common pleas court's order reversing in part and affirming in part the department's adjudication order.

The department's adjudication order concluded that CHS owed the department $11,111,557.96 in Medicaid provider overpayments. The overpayment finding was the result of two types of audits: cost report audits of the CHS facilities' calendar year 2003 cost reports and days audits of the days the facilities were paid for rendering services to Medicaid recipients between 2003 and 2006. The primary issue in the direct appeal concerned the department's application of the liquidation of liabilities rule to the CHS facilities' 2003 cost reports.

{¶ 10} The liquidation of liabilities rule is contained in 42 C.F.R. 413.100 and the provider reimbursement manual ("PRM") section 2305. Ohio Adm.Code 5101:3-3-01(A) provides that allowable costs for Medicaid cost reporting purposes are to be determined according to the following reference material in the following priority: (1) Title 42 C.F.R. Chapter IV, (2) the PRM, or (3) generally accepted accounting principles ("GAAP"). "Although 42 C.F.R. Chapter IV and the PRM are rules and interpretative guidelines applicable to Medicare cost reports, Ohio incorporated these rules into Ohio Adm.Code 5101:3-3-01(A) thereby making the liquidation of liabilities rule applicable to Ohio Medicaid cost reports." *CHS-Lake Erie* at ¶ 54. 42 C.F.R. 413.100 provides that "a short term liability * * * must be liquidated within 1 year after the end of the cost reporting period in which the liability is incurred." 42 C.F.R. 413.100(c)(2)(i)(A). PRM section 2305 provides that if the liquidation of a short-term liability "is made by check or other negotiable instrument, these forms of payment must be redeemed

through an actual transfer of the provider's assets within the" one-year time limit.

{¶ 11} The costs at issue in *CHS-Lake Erie* were certain consulting costs the CHS facilities incurred in 2003. The consulting costs were short-term liabilities, and the facilities failed to timely liquidate the consulting costs pursuant to the requirements of 42 C.F.R. 413.100 and PRM section 2305. As such, the department disallowed the relevant consulting costs from the facilities' 2003 cost reports. In *CHS-Lake Erie,* we found the department correctly applied the liquidation of liabilities rule to the consulting costs. *Id.* at ¶ 66.

{¶ 12} The common pleas court reversed the department's application of the liquidation of liabilities rule based on the court's conclusion that the "department had 'ignor[ed] the competent and credible evidence demonstrating that Medicare would not have applied the rule to the transaction at issue.'" *CHS-Lake Erie* at ¶ 36, quoting Trial Court Decision at 8. Ohio's Medicaid reimbursement system in 2003 was a prospective cost-based system of reimbursement. In the prospective cost-based system, the department used the actual costs reported on a facility's cost report to establish a unique per diem rate for the facility for the subsequent fiscal year. *Id.* at ¶ 24. In contrast, the Medicare prospective payment system relied on prospectively fixed rates for each category of treatment rendered. *Id.* at ¶ 60. The Federal Register explains that 42 C.F.R 413.100 "pertains to all services furnished by providers" in the Medicare system other than services paid for "on a prospective payment basis."

Id. at ¶ 59. John Hapchuk, a former auditor for the Medicare and Medicaid programs in the United States Department of Health and Human Services, testified at the department hearings that the liquidation of liabilities rule did not apply in Ohio in 2003 because Ohio used "[a] prospective payment system" like the Medicare prospective payment system and "had moved away from the cost reimbursement to basically setting prices." *Id.* at ¶ 23.

{¶ 13} In *CHS-Lake Erie,* we observed that the department's hearing examiner had addressed both Hapchuk's and the Federal Register's statements indicating the liquidation of liabilities rule did not apply in the Medicare prospective payment system. *Id.* at ¶ 62-63. The hearing examiner concluded that because "providers in Ohio were reimbursed based upon costs incurred rather than services provided, * * * Ohio's prospective cost-based system differed from the Medicare prospective payment system." *Id.* at ¶ 63. The hearing examiner also noted the "reliability issues present in Hapchuk's testimony," as Hapchuk "admitted he was not familiar with the rules applicable to Ohio's Medicaid cost reports." *Id.* at ¶ 62. As the department had addressed and distinguished the evidence demonstrating that Medicare would not apply the liquidation of liabilities rule in the Medicare prospective payment system, we concluded in *CHS-Lake Erie* that the common pleas court "abused its discretion by holding that the department had ignored the evidence concerning Medicare's application of the liquidation of liabilities rule." *Id.* at ¶ 64. Accordingly, CHS's contention that *CHS-Lake Erie* contains "no discussion on how the common pleas decision was

'unreasonable, arbitrary, or unconscionable'" lacks merit. (Appellees/Cross-Appellants' App. for Recon. at 8.)

{¶ 14} CHS asserts in its application for reconsideration that the liquidation of liabilities rule "cannot be applied in a prospective [payment] system," whether the prospective payment system is "based on past costs or a fixed or negotiated rate." (Appellees/Cross-Appellants' App. for Recon. at 4.) To support its assertion, CHS cites to various provisions of 42 C.F.R. 413 which demonstrate that Medicare has a retrospective system of cost reimbursement for providers who are not subject to the Medicare prospective payment system. (Appellees/Cross-Appellants' App. for Recon. at 3, 6-7, 13.) *See* 42 C.F.R. 413.1(b) (noting that "[e]xcept as provided" in the paragraphs addressing the prospective payment system, Medicare will pay for services furnished by its providers on the "basis of reasonable costs"); 42 C.F.R. 413.5 (stating general principles of Medicare retrospective cost reimbursement); 42 C.F.R. 413.60 (detailing how the Medicare fiscal contractors will make payments to providers under the retrospective payment system). *Compare* 42 C.F.R. 413.1(d)(2) (noting that Medicare payments for inpatient hospital services after October 1, 1983 "are determined prospectively on a per discharge basis"); 42 C.F.R. 413.1(g)(2)(i) (noting that the amount "paid" by Medicare for services furnished in a nursing facility "on or after July 1, 1998, * * * is determined in accordance with the prospectively determined payment rates").

{¶ 15} The fact that Medicare retained its retrospective payment system for providers not subject to the Medicare prospective payment system does not demonstrate that the liquidation of liabilities rule could not apply in Ohio's prospective cost-based payment system. Under Ohio's prospective cost-based system, the department used the actual costs reported on a facility's annual cost report to establish a prospective per diem rate for the facility for the subsequent fiscal year. *CHS-Lake Erie* at ¶ 24. Unlike the Ohio prospective cost-based system, the Medicare prospective payment system utilizes only pre-set rates of payment and does not consider the actual costs incurred by the provider. *Accord Anna Jacques Hosp. v Burwell,* 797 F.3d 1155, 1157-58 (D.C.Cir.2015) (explaining that the Medicare "Prospective Payment System reimburses hospitals for medical care * * * on the basis of a pre-established formula, regardless of the actual costs incurred by the hospital"); *Abington Mem. Hosp. v. Burwell,* 216 F.Supp.3d 110, 117 (D.C.Cir.2016) (noting that in the Medicare prospective payment system hospitals are "given advance notice of the pre-established rates at which inpatient services will be reimbursed," and hospitals are "reimbursed at those pre-set rates, irrespective of the costs the hospital actually incurs"). Accordingly, the statements contained in the Federal Register and case law demonstrating that the liquidation of liabilities rule does not apply in the Medicare prospective payment system demonstrate only that the rule does not apply in a prospective payment system based on pre-set rates. CHS fails to cite any authority demonstrating that the liquidation of liabilities rule did not apply in Ohio's prospective cost-based system of reimbursement.

{¶ 16} CHS contends the testimony from Hapchuk, Bert Cummins, and John Fleischer was "reliable, probative, and substantial" evidence demonstrating it was "not possible to apply the Liquidation of Liabilities Rule to a prospective payment system." (Appellees/ Cross Appellants' App. for Recon. at 15.) We addressed Hapchuk, Cummins, and Fleischer's testimonies in *CHS-Lake Erie*.

{¶ 17} Hapchuk's testimony was not reliable. Indeed, Hapchuk admitted he was not familiar with Ohio's Medicaid reimbursement system and mistakenly stated that Ohio utilized a pricing system in 2003. *CHS-Lake Erie* at ¶57-58. Although Cummins testified that the liquidation of liabilities rule could not apply in a "prospective system," he stated the liquidation of liabilities rule did apply "in a cost-based or reasonable cost system." (Tr. Vol. VI at 748.) Ohio's Medicaid payment system in 2003 was a cost-based system. Fleischer testified that the liquidation of liabilities rule "no longer [made] sense" because Ohio changed its Medicaid reimbursement system in 2004, but affirmed "that the rules made sense prior to the change in legislation." *CHS-Lake Erie* at ¶ 21. Thus, Fleischer affirmed the liquidation of liabilities rule made sense in Ohio in 2003.

{¶ 18} CHS asserts that certain acts of the General Assembly which altered the Medicaid reimbursement system in Ohio for fiscal years 2006, 2007, 2008, and 2009 demonstrate that the "Liquidation of Liabilities Rule may not be applied" in the present case. (Appellees/Cross-Appellants' App. for Recon. at 10.) In *CHS-Lake Erie,* we recognized that the General

Assembly changed Ohio's Medicaid payment system beginning on July 1, 2004, when Ohio began to transition to a price-based prospective payment system. *Id.* at ¶ 25. However, *CHS-Lake Erie* concerned the costs reported on the facilities' 2003 cost reports. As such, the legislative changes to Ohio's Medicaid reimbursement system after 2003 were not relevant to determining whether the costs reported on the facilities' 2003 cost reports were allowable.

{¶ 19} CHS notes that 2004 Am.Sub.H.B. No. 95 was "in effect in 2003." (Appellees/Cross-Appellants' App. for Recon. at 10.) 2004Am.Sub.H.B. No. 95 established rate caps on the per diem rates Medicaid facilities would receive in fiscal years 2004 and 2005. *See* 2004 Am.Sub.H.B. No. 95, Section 59.37(B)(1) and (2).[1] The department used the costs reported on the facilities' calendar year 2003 cost reports to establish the facilities' per diem rates for fiscal year 2005. *CHS-Lake Erie* at ¶ 6. Testimony at the agency hearings demonstrated the facilities' fiscal year 2005 per diem rates were "subject to ceilings." (Tr. Vol. VIII at 1009.) However, the fact that rate caps or ceilings would be applied to the CHS facilities' fiscal year 2005 per diem rates did not render the liquidation of liabilities rule inapplicable to the facilities' 2003 cost reports.

{¶ 20} The CHS facilities paid a portion of the consulting costs at issue in *CHS-Lake Erie* by issuing promissory notes. The facilities issued the promissory notes on December 31, 2003, and pursuant to the terms

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[1] Accessible at http://archives.legislature.state.oh.us/BillText125/125_HB_95_EN2_N.html.

of the notes did not make payments on the notes until 2005. *CHS-Lake Erie* at ¶ 13. As the payments on the promissory notes did not occur until over one year after the end of the 2003 cost reporting period, the liquidation of liabilities rule mandated that the costs associated with the promissory notes "were not allowable on the facilities' 2003 cost reports." *Id.* at ¶ 71.

{¶ 21} CHS contends that "[u]nder Ohio's Uniform Commercial Code" the promissory notes amounted to "payment in full" of the consulting costs at issue. (Appellees/Cross-Appellants' App. for Recon. at 18-19.) As we explained in *CHS-Lake Erie,* "[a]lthough the promissory notes at issue were negotiable instruments under R.C. 1303.03(A) (Uniform Commercial Code 3-104), the present case is concerned with the specific Ohio Medicaid cost reporting rules rather than general rules concerning negotiable instruments." *Id.* at ¶ 70, fn. 11. Thus, while "the presentation of a promissory note is sufficient to liquidate a debt for purposes of GAAP, the Medicare regulations which Ohio adopted in Ohio Adm.Code 5101:3-3-01(A) place additional requirements on this method of liquidation for cost reporting purposes." *Id.* at ¶ 70.

{¶ 22} CHS contends the department's interpretation of 42 C.F.R. 413.100 and PRM section 2305 was not entitled to deference because the "Liquidation of Liabilities Rule is *not* an ODM rule; it is a federal Medicare rule." (Emphasis sic.) (Appellees/Cross-Appellants' App. for Recon. at 14.) However, Ohio incorporated 42 C.F.R. 413.100 and PRM section 2305 into Ohio Adm.Code 5101:3-3-01(A),

"thereby making the liquidation of liabilities rule applicable to Ohio Medicaid cost reports." *Id.* at ¶ 54. And what we correctly held was that "the department's conclusion that 42 C.F.R. 413.100 and PRM 2305 applied to the 2003 cost reports was entirely in keeping with *and required by* the plain language of Ohio Adm.Code 5101:3-3-01(A)." (Emphasis added.) *Id.* at ¶ 66.

{¶ 23} CHS essentially seeks to rehash the same arguments it made in *CHS-Lake Erie.* Although CHS disagrees with this court's conclusion that the liquidation of liabilities rule applied to the CHS facilities' 2003 cost reports, CHS fails to point to an obvious error in our decision or raise an issue for consideration that was not fully considered by this court when it should have been.

{¶ 24} CHS additionally asserts this court made an obvious error in affirming the common pleas court's ruling on the unpaid days and unpaid claims issue in the days audit. The common pleas court affirmed the department's motion in limine ruling which precluded CHS from offering evidence of unpaid days or unpaid claims for service at the R.C. Chapter 119 hearings. In *CHS-Lake Erie,* we observed that CHS "had no right under R.C. 5111.06 to address the unpaid days and unpaid claims at the R.C. Chapter 119 hearing on the final fiscal audits." *Id.* at ¶ 79. R.C. 5111.06(B)(2)[2]

[2] The Medicaid reimbursement statutes and rules have been revised since the time of the events at issue in this case. All references to R.C. Chapter 5111 and Ohio Adm.Code Chapter 5101

provides for R.C. Chapter 119 hearing rights when the department takes "any action based upon a final fiscal audit." As "an audit reviews payment made to 'determine the amount of overpayment,'" CHS's unpaid days and unpaid claims were never reviewed by the department in the audit and could not be addressed at the R.C. Chapter 119 hearings. *Id.* at ¶ 78, quoting Ohio Adm.Code 5101:3-1-27(B)(1).

{¶ 25} CHS contends it should have been permitted to introduce evidence of unpaid days at the R.C. Chapter 119 hearings because the "unpaid days" were "in the same audit period as the days that were paid and adjusted by ODM." (Appellees/Cross-Appellants' App. for Recon. at 20.) However, the fact that the unpaid days occurred in the same audit period as the paid days does not establish that CHS was entitled to address the unpaid days at the R.C. Chapter 119 hearings. The department necessarily never paid CHS for the unpaid days and, thus, never reviewed the unpaid days in auditing the CHS facilities. CHS fails to point to an obvious error in *CHS-Lake Erie.*

{¶ 26} Based on the foregoing, CHS's application for reconsideration is denied.

III. Application for Consideration En Banc Denied

{¶ 27} An en banc proceeding is one in which all full-time judges of a court who have not recused

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throughout this decision are to the versions of those statutes and rules in effect during the fiscal years for which the department sought repayment.

themselves or otherwise been disqualified participate in the hearing and resolution of a case. App.R. 26(A)(2)(a); *McFadden* at ¶ 10. An en banc proceeding seeks to resolve conflicts of law that arise within a district. App.R. 26(A)(2)(a); *McFadden* at ¶ 10, 15-16. These intradistrict conflicts develop when different panels of judges hear the same issue, but reach different results. *McFadden* at ¶ 15. This "create[s] confusion for lawyers and litigants and do[es] not promote public confidence in the judiciary." *J.J.* at ¶ 18. "Resolution of intradistrict conflicts promotes uniformity and predictability in the law, and a larger appellate panel provides the best possible means of resolution." *State v. Forrest,* 136 Ohio St.3d 134, 2013-Ohio-2409, ¶ 7, citing *McFadden* at ¶ 15-16.

{¶ 28} App.R. 26(A)(2) governs en banc procedures, providing as follows:

> (a) Upon a determination that two or more decisions of the court on which they sit are in conflict, a majority of the en banc court may order that an appeal or other proceeding be considered en banc. * * * Consideration en banc is not favored and will not be ordered unless necessary to secure or maintain uniformity of decisions within the district on an issue that is dispositive in the case in which the application is filed.
>
> (b) * * * An application for en banc consideration must explain how the panel's decision conflicts with a prior panel's decision on a dispositive issue and why consideration by the court en

> banc is necessary to secure and maintain uniformity of the court's decisions.

{¶ 29} "[C]onflicting decisions are those which conflict on the same legal issue or question of law." *Frash v. Ohio Dept. of Rehab. & Corr.*, 10th Dist. No. 14-AP-932, 2016-Ohio-3134, ¶ 3, citing *J.J.* at ¶ 18. Courts of appeals have discretion to determine whether an intradistrict conflict exists. *McFadden* at paragraph two of the syllabus.

{¶ 30} CHS's contention that a conflict exists between *CHS-Lake Erie* and *Meadowbrook Care Ctr.* and *OMG MSTR LSCO, LLC* is premised on CHS's inaccurate portrayal of certain events which took place at the agency hearings. CHS contends that during the R.C. Chapter 119 hearings the department "determined that some of the patient days the agency had previously refused to pay, should have been paid." (Appellees/Cross-Appellants' Mot. to Certify a Conflict, as converted to App. For Consideration En Banc (hereafter, "Appellees/Cross-Appellants' App. for Consideration En Banc") at 3.) Based on CHS's belief that the department decided to pay previously unpaid patient days at the R.C. Chapter 119 hearings, CHS contends it was required to present other evidence of previously unpaid patient days at the hearings.

{¶ 31} However, the department never determined that previously unpaid patient days should be paid at the hearings as CHS contends. The department introduced a number of exhibits detailing its adjustments to the paid patient days at issue in the days audit at the January 22, 2013 hearing. At the April 8, 2013 hearing, "the department introduced four

exhibits to replace four of the exhibits previously introduced at the January 22, 2013 hearing." *CHS-Lake Erie* at ¶ 82. Kierstyn Canter, a department audit manager, explained that the difference between the initial exhibits and the revised exhibits was that the department had "deleted an adjustment to create less of an overpayment." (Tr. Vol. VI at 670.) CHS's counsel asked Canter if the revised exhibits demonstrated that CHS "was entitled to additional revenue for the settlement periods reflected in those four exhibits." (Tr. Vol. VI at 670.) Canter stated the revised exhibits did not reflect any additional revenue going to CHS, but rather reflected "just a reduction in the amount that the provider owes back to [the department]." (Tr. Vol. VI at 670.)

{¶ 32} In *Meadowbrook Care Ctr.,* a nursing facility argued that the department's audit of the facility's patient days did not constitute a final fiscal audit pursuant to R.C. 5111.06(B)(2). The days audit in *Meadowbrook Care Ctr.* consisted of "a comparison and reconciliation with [the department's] records of amounts paid to other providers" such as "hospice or hospital, for the same patient." *Id.* at ¶ 14. The *Meadowbrook Care Ctr.* court concluded the department's "audit procedures in undertaking the limited adjustments proposed in its adjudication order complied with R.C. 5111.06 and 5111.27." *Id.* at ¶ 21.

{¶ 33} CHS asserts that in "*Meadowbrook,* the facility received a hearing; here, CHS did not." (Appellees/Cross-Appellants' App. For Consideration En Banc at 8.) CHS's contention that it did not receive a hearing is premised on its mistaken belief that it was

entitled to introduce evidence of unpaid patient days at the R.C. Chapter 119 hearings. In *Meadowbrook Care Ctr.,* the nursing facility did not attempt to introduce evidence of unpaid days at the R.C. Chapter 119 hearing. Rather, the issue in *Meadowbrook Care Ctr.* was whether the department's method of auditing the facility's patient days was sufficient. There is no conflict on an issue of law between *CHS-Lake Erie* and *Meadowbrook Care Ctr.*

{¶ 34} In *OMG MSTR LSCO, LLC,* the department initiated proceedings against certain long-term care facilities to recover alleged Medicaid overpayments. The facilities filed a complaint in the common pleas court seeking a declaratory judgment that the department's attempt to collect the alleged overpayments was time-barred. The common pleas court granted the department's Civ.R. 12(B)(6) motion to dismiss the complaint based on the facilities' failure to exhaust their administrative remedies. The face of the facilities' complaint demonstrated they had failed to exhaust their administrative remedies and that the limited exceptions to the doctrine did not apply. As such, the *OMG MSTR LSCO, LLC* court concluded that the "declaratory judgment action must be dismissed due to appellants' failure to exhaust their administrative remedies." *Id.* at ¶ 19.

{¶ 35} CHS asserts that pursuant to *OMG MSTR LSCO, LLC* it has "absolutely no remedy at all" because it did not "receive a hearing on patient days." (Appellees/Cross-Appellants' App. for Consideration En Banc at 14-15.) However, CHS received an R.C. Chapter 119 hearing on the patient days at issue in the

department's final fiscal audits, and appealed the department's ruling on the patient days to the common pleas court and this court. *CHS-Lake Erie* did not concern any issue regarding the failure to exhaust administrative remedies doctrine. There is no conflict on an issue of law between *OMG MSTR LSCO, LLC* and *CHS-Lake Erie*. Moreover, CHS's contention that it has no remedy for its unpaid days lacks merit. In *CHS-Lake Erie,* this court explained that CHS has available avenues of relief to address its contentions regarding the unpaid days, including seeking reconsideration pursuant to Ohio Adm.Code 5101:3-1-57(B) or seeking a writ of mandamus to force the agency to act on its claims for payment. *Id.* at ¶ 80-81.

{¶ 36} Based on the foregoing, CHS's application for consideration en banc is denied.

{¶ 37} CHS's motion to convert its motion to certify a conflict into an application for consideration en banc and motion to exceed page limitation are granted; CHS's motion to certify a conflict is withdrawn. CHS's application for reconsideration and application for consideration en banc are denied.

Motion to convert granted;
motion to exceed page limit granted;
motion to certify a conflict withdrawn;
application for reconsideration denied;
application for consideration en banc denied.

LUPER SCHUSTER and NELSON, JJ., concur.

APPENDIX C

IN THE COURT OF COMMON PLEAS OF FRANKLIN COUNTY, OHIO CIVIL DIVISION

Case No. 16CV9766

JUDGE SERROTT

[Filed: April 21, 2020]

CHS-Lake Erie, Inc. et al.,	)
	)
Appellants,	)
	)
-v-	)
Ohio Department of Medicaid,	)
	)
Appellee.	)
	)

DECISION AND ORDER

I. Introduction

This case is before the Court on remand from a decision rendered by the Tenth District Court of Appeals ("Tenth District") on February 13, 2020 ("Appellate Court Decision"). After a thorough review of the Appellate Court Decision, this Court hereby renders the following decision that conforms with the requirements laid forth by the Tenth District.

II. Background

On October 30, 2018, this Court rendered a decision in this case ("Trial Court Decision"), which affirmed in part, and reversed in part, the Adjudication Order of Appellee, the Ohio Department of Medicaid ("Appellee"). Appellants, CHS-Lake Erie, Inc. et al. ("Appellant"), are related Medicaid-provider nursing homes, and appealed from Appellee's Adjudication Order following an audit of the nursing facilities cost reports from 2003. The Adjudication Order adopted in full the Hearing Officer's Report and Recommendation that Appellants were not entitled to reimbursement for claimed costs of $11,111,557.96. After a full review of the record and relevant law this Court affirmed the Adjudication Order with the exception of Appellants' argument that Appellee improperly applied the liquidation-of-liability rule to the 2003 cost reports, an error that was sustained.

On November 26, 2018, Appellee appealed the Trial Court Decision to the Tenth District and on November 27, 2018, Appellants cross-appealed. On February 13, 2020, in the Appellate Court Decision, the Tenth District affirmed in part and reversed in part the Trial Court Decision. Specifically, Appellants' four assignments of error on cross-appeal were overruled, but the Appellee's sole assignment of error on the liquidation-of-liabilities rule was sustained, the latter of which was remanded to this Court.

III. Analysis

The Tenth District remanded this case to this Court on the sole issue of the liquidation-of-liabilities rule.

The Tenth District deemed that this Court erred by ruling that the Appellee incorrectly construed and applied the liquidation-of-liabilities rule to disallow the consulting costs in Appellants' 2003 cost reports. Accordingly, this Court now renders a decision that allows the liquidation-of-liabilities rule to apply to Appellants' 2003 cost reports. In other words, the original Adjudication Order of Appellee is now affirmed in all respects.

IV. Conclusion

By rendering this decision, the Court complies with the remand requirements of the Appellate Court Decision. Because there are no remaining issues to be decided, the case is hereby terminated.

IT IS SO ORDERED.

Electronically Signed By:

JUDGE MARK A. SERROTT

Franklin County Court of Common Pleas

Date:	04-21-2020
Case Title:	CHS-LAKE ERIE INC ET AL - VS-OHIO DEPARTMENT MEDICAID
Case Number:	16CV009766
Type:	DECISION

It Is So Ordered.

/s/ Judge Mark A. Serrott

Court Disposition

Case Number: 16CV009766

Case Style: CHS-LAKE ERIE INC ET AL -VS- OHIO DEPARTMENT MEDICAID

Case Terminated: 18 - Other Terminations

APPENDIX D

IN THE COURT OF APPEALS OF OHIO
TENTH APPELLATE DISTRICT

No. 18AP-897
(C.P.C. No. 16CV-9766)

(REGULAR CALENDAR)

[Filed: February 13, 2020]

CHS-Lake Erie, Inc. et al.,	)
	)
Appellants-Appellees/ Cross-Appellants,	)
	)
v.	)
	)
Ohio Department of Medicaid,	)
	)
Appellee-Appellant/ Cross-Appellee.	)
	)

DECISION

Rendered on February 13, 2020

On brief: *Webster* & *Associates, Co., LPA,* and *Geoffrey E. Webster,* for appellees/cross-appellants. **Argued:** *Geoffrey E. Webster*.

On brief: *Dave Yost,* Attorney General, and *Rebecca L. Thomas,* for appellant/cross-appellee. **Argued:** *Rebecca L. Thomas.*

APPEAL from the Franklin County Court of Common Pleas

BEATTY BLUNT, J.

{¶ 1} Appellant/cross-appellee, the Ohio Department of Medicaid (the "department")[1] appeals from a judgment of the Franklin County Court of Common Pleas affirming in part and reversing in part the department's adjudication order determining that appellees/cross-appellants, CHS-Glenwell, Inc. (dba Glen Meadows), CHS-Glenwell, Inc. (dba Wellington Manor), CHS-Greater Cincinnati, Inc. (dba East Galbraith Health Care Center ("East Galbraith")), CHS-Lake Erie, Inc. (dba Carington Park), CHS-Miami Valley, Inc. (dba Vandalia Park), CHS-Miami Valley, Inc. (dba Franklin Ridge), and CHS-Ohio Valley, Inc. (dba Terrace View Gardens) (collectively, "CHS"[2] or

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[1] Pursuant to 2013 Am.Sub.H.B. No. 59, the General Assembly created the Ohio Department of Medicaid effective July 1, 2013. The Ohio Department of Medicaid assumed responsibility and authority over the Ohio Medicaid cases previously under jurisdiction of the Ohio Department of Job and Family Services. References to the "department" throughout this decision refer either to the Ohio Department of Job and Family Services or the Ohio Department of Medicaid interchangeably depending on the relevant time frame.

[2] Although Carington Health Systems, the parent corporation to the facilities at issue, operates other long-term care facilities, references to CHS herein refer only to the seven named facilities.

"the facilities") owed the department $11,111,557.96 in Medicaid provider overpayments. For the reasons which follow, we affirm in part and reverse in part the judgment of the common pleas court.

I. Facts and Procedural History

{¶ 2} CHS operates long-term care facilities, providing room, board, and nursing services to persons eligible for benefits under Ohio's Medicaid program. Pursuant to R.C. Chapter 5111[3] and Title XIX of the Social Security Act, the department administers the Medicaid program in Ohio.

{¶ 3} In 2009, the department issued proposed adjudication orders to CHS. The proposed adjudication orders informed CHS that the department intended to implement the findings of final fiscal audits, which demonstrated that CHS had received an overpayment of Medicaid funds. CHS timely requested R.C. Chapter 119 hearings on the proposed adjudication orders. The department consolidated the matter into a single proceeding and appointed a hearing examiner.

{¶ 4} The department conducted two types of audits in this case: cost report audits and days audits. In the cost report audits, the department audited the calendar

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[3] The Medicaid reimbursement statutes and rules have been revised since the time of the events at issue in this case. All references to R.C. Chapter 5111 and Ohio Administrative Code Chapter 5101 throughout this decision are to the versions of those statutes and rules in effect during the fiscal years for which the department sought repayment.

year[4] 2003 cost reports filed by Carington Park, Terrace View Gardens, Vandalia Park, and Franklin Ridge; the six-month cost report filed by East Galbraith covering July 1 to December 31, 2003; and the three-month cost reports filed by Glen Meadows and Wellington Manor covering December 1, 2003 to February 29, 2004. The hearing examiner referred to all the cost reports as the 2003 cost reports.

{¶ 5} Nursing facilities report their yearly operating costs to the Medicaid program through cost reports. Nursing facilities prepare cost reports using the accrual basis of accounting. The 2003 cost reports contained separate cost centers for direct care costs, indirect care costs, capital costs, and other protected costs.

{¶ 6} From fiscal year[5] 1994 to fiscal year 2005, Ohio used a nursing facility's calendar year cost report to establish the facility's per diem rate for the subsequent fiscal year. For example, the calendar year 1994 cost report established the per diem rate for fiscal year 1996, and the calendar year 1995 cost report established the per diem rate for fiscal year 1997. *Bryant Health Care Ctr. v. Ohio Dept. of Job & Family Servs.,* 10th Dist. No. 13AP-263, 2014-Ohio-92, ¶ 6. Thus, the facilities' calendar year 2003 cost reports established the facilities per diem rates for fiscal year

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[4] A calendar year went from January 1 to December 31; for example, calendar year 2003 went from January 1 to December 31, 2003.

[5] A state fiscal year went from July 1 to June 30; for example, state fiscal year 2005 went from July 1, 2004 to June 30, 2005.

2005. The per diem rate was the amount the facility received per resident per day. *Id.* at ¶ 5.

{¶ 7} In the days audits, the department reviewed the days the facilities were paid for rendering services to Medicaid recipients ("patient days") and reviewed the funds the facilities collected from their Medicaid recipients ("patient liability"). In reviewing the patient days, the department sought to determine whether the facilities actually provided each resident care for the number of days the facility claimed to have provided such care. *See Clifton Care Ctr. v. Ohio Dept. of Job & Family Servs.,* 10th Dist. No. 12AP-709, 2013-Ohio-2742, ¶ 15; *Meadowbrook Care Ctr. v. Ohio Dept. of Job & Family Servs.,* 10th Dist. No. 06AP-871, 2007-Ohio-6534, ¶ 14. In reviewing the patient liability amounts, the department assessed whether CHS had collected the proper amount of contribution from each resident. Medicaid recipients may be required to contribute to the cost of their care depending on their income, and the difference between "the individual's patient liability and the monthly medicaid cost of care is the medicaid vendor payment amount." Ohio Adm.Code 5101:1-39-22.2(B). The department audited the patient days and patient liability amounts for the following facilities during the following fiscal years: Carington Park, Terrace View Gardens, Vandalia Park, Franklin Ridge, and East Galbraith for 2003, 2004, 2005, and 2006; Glen Meadows for 2004, 2005, and 2006; and Wellington Manor for 2005 and 2006.

{¶ 8} The hearing before the department proceeded in two phases. Phase one concerned the threshold issue of whether the department, acting through the auditing

firm Clifton Gunderson, had conducted qualifying audits of CHS's 2003 cost reports. The phase one hearings occurred on September 28, September 29, and October 5, 2009. The hearing examiner concluded the department had conducted audits of the 2003 cost reports.

{¶ 9} Phase two concerned the merits of the department's proposed audit adjustments under both the cost report audits and the days audits. The phase two hearings occurred on December 10 and 11, 2012, and January 22, January 23, January 24, April 8, April 9, April 10, and May 17, 2013. One of the issues addressed at the phase two hearings was the department's disallowance of certain consulting costs from the 2003 cost reports based on the liquidation of liabilities rule. Prior to the start of the phase two hearings, CHS filed a motion in limine seeking to block all evidence and testimony relating to the liquidation of liabilities rule. The hearing examiner denied CHS's motion.

{¶ 10} The consulting costs at issue concerned some of the facilities contracts with Strategic Nursing Systems, Inc. ("Strategic") and Providers Choice Administrative Services, Inc. ("Providers Choice"). The parties stipulated that Carington Park, Terrace View Gardens, Franklin Ridge, Vandalia Park, and East Galbraith contracted with Strategic for direct care consulting services in 2003. The parties stipulated that Carington Park, Terrace View Gardens, Franklin Ridge, Vandalia Park, and East Galbraith contracted with Providers Choice for indirect care consulting services in 2003. The noted facilities reported their

costs from Strategic and Providers Choice on their 2003 cost reports. Although the parties did not enter into any stipulations regarding Glen Meadows and Wellington Manor, these facilities reported costs related to Strategic on their three-month cost reports.

{¶ 11} Carington Park, Terrace View Gardens, Franklin Ridge, and Vandalia Park entered into yearlong contracts with both Strategic and Providers Choice beginning on January 1, 2003. East Galbraith entered into six-month contracts with Strategic and Providers Choice beginning on July 1, 2003. The contracts with both Strategic and Providers Choice provided for annual services ("Annual Services") and stated that the fees for the Annual Services would be payable in monthly installments. The monthly invoices issued throughout 2003 pursuant to the Annual Services portions of the contracts stated the invoices were "due upon receipt of invoice." (State's Ex. 58, 64, 93, 99, 120, 126, 155, 158, and 182.) The facilities paid the Annual Services monthly invoices by check.

{¶ 12} The contracts between Carington Park, Terrace View Gardens, Franklin Ridge, East Galbraith, and Strategic, as well as the contracts between Carington Park, Terrace View Gardens, Franklin Ridge, Vandalia Park, East Galbraith, and Providers Choice, also contained attachments providing for additional enhanced services ("Enhanced Services"). The attachments stated that the entire fee for the Enhanced Services would be invoiced to the facilities on December 31, 2003. The noted facilities issued promissory notes to Strategic and Providers Choice on

December 31, 2003 as payment for the Enhanced Services fees.

{¶ 13} The December 31, 2003 promissory notes issued from the facilities to Strategic stated the unpaid principal and accrued interest would be payable in monthly installments beginning August 1, 2005. The December 31, 2003 promissory notes issued from the facilities to Providers Choice stated the unpaid principal and accrued interest would be payable in monthly installments beginning February 1, 2005. The facilities paid the promissory notes pursuant to their terms and, thus, did not make payments on the notes until 2005.

{¶ 14} Following its initial audit of CHS, Clifton Gunderson disallowed the Strategic and Providers Choice costs from the 2003 cost reports due to lack of documentation and a suspected related party issue.[6] After CHS produced documentation during discovery to support the Strategic and Providers Choice costs, the auditors identified the liquidation of liabilities issue. At the beginning of the phase two hearings, the parties

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[6] The auditors noted a suspected related party issue because the owners of CHS reported owning Strategic on their 2004 tax returns, and CHS failed to produce documentation to the auditors demonstrating that CHS did not own Strategic or Providers Choice in 2003. During discovery, CHS produced a purchase agreement demonstrating that the owners of CHS purchased Strategic on August 29, 2004 for $4.6 million. When CHS purchased Strategic, it owed Strategic $12 million. Thus, after the purchase CHS "owed the money to themselves. Strategic ha[d] a receivable of $12 million. The companies had a payable of $12 million. And when it was acquired, it became part of the combination, and they eliminated." (Tr. Vol. VII at 894.)

stipulated that the department would proceed on the liquidation of liabilities issue as the proposed basis for disallowance of the consulting costs.

{¶ 15} Emily Hess, a senior manager at Clifton Gunderson who oversaw the CHS audit, explained there was a hierarchy of authorities the auditors used to determine what costs were allowable on the 2003 cost reports. The hierarchy, contained in Ohio Adm.Code 5101:3-3-01(A), consisted in order of authority of the Ohio Revised Code, the Ohio Administrative Code, Title 42 of the Code of Federal Regulations ("C.F.R.") Chapter IV, the Provider Reimbursement Manual[7] ("PRM"), and Generally Accepted Accounting Principles ("GAAP"). The liquidation of liabilities rule is contained in 42 C.F.R. 413.100 and PRM 2305. Because neither the Ohio Revised Code nor the Ohio Administrative Code address the timely liquidation of liabilities for cost reporting purposes, the auditors followed the hierarchy to apply 42 C.F.R. 413.100 and PRM 2305 to the 2003 cost reports.

{¶ 16} Hess explained that under the liquidation of liabilities rule, "[i]n order to be claimed on the cost reports" a short-term liability "must be expended or funds expended within a year of that cost report period." (Tr. Vol. II at 113.) Thus, for a short-term liability to be claimed on the 2003 cost report, the facility "would have to have those funds expended

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[7] The Provider Reimbursement Manual is accessible at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals-Items/CMS021929.html.

basically by the end of 2004 or 12/31/2004." (Tr. Vol. II at 111.) A short-term liability is a liability payable "within 12 months." (Tr. Vol. II at 113.) Because the Strategic and Providers Choice invoices were due upon receipt, Hess stated the invoices were all short-term liabilities.

{¶ 17} Hess noted that "most of the[] transactions" under the Annual Services portions of the contracts were allowable because the facilities paid the monthly invoices in either 2003 or 2004. However, Hess noted a few transactions under the Annual Services portions of the contracts which were not allowable because they were not paid until 2005. For example, Carington Park paid the November 30, 2003 Strategic Annual Services monthly invoice on March 28, 2005.

{¶ 18} Hess explained that PRM 2305 provided that if a short-term liability was paid by check or negotiable instrument, the instrument had "to be cashed and paid" and "funds transferred from one entity to the other" within "one year of the cost report period end date." (Tr. Vol. II at 114-15.) Accordingly, because the facilities did not transfer any funds to redeem the December 31, 2003 promissory notes until 2005, over one year after the end of the 2003 cost reporting period, Hess stated that the Enhanced Services costs were not allowable on the 2003 cost reports. Hess noted the payments made toward the promissory notes in 2005 "would be allowed on the 2005 cost reports," and the payments made toward the notes in 2006 would be allowable on the "2006 cost report," and so on for the remaining years. (Tr. Vol. VI at 134.)

{¶ 19} CHS presented testimony from Bert Cummins, John Fleischer, and John Hapchuk to support its contention that the liquidation of liabilities rule did not apply to the 2003 cost reports. Cummins and Fleischer, both certified public accountants whose work focused on the long-term care industry in Ohio, stated they had never seen the department apply the liquidation of liabilities rule in an audit. Cummins asserted that the liquidation of liabilities rule could not apply to the 2003 cost reports because there was "no way that costs can be disallowed out of the 2003 cost report period and placed into a subsequent payment period." (Tr. Vol. II at 747-48.)

{¶ 20} Fleischer explained that because 42 C.F.R. 413.100 and PRM 2305 were Medicare rules, he was "not so sure" if the rules applied "for Medicaid." (Tr. Vol. II at 244.) However, Fleischer affirmed that the C.F.R. and the PRM were in the hierarchy of authorities applicable to Ohio Medicaid cost reports. Fleisher acknowledged the requirements of PRM 2305 but stated that in his opinion "if you were to take an ordinary expense and make it part of a long-term liability, I think at that point you're done. The liability has been liquidated within one year." (Tr. Vol. II at 240-41.)

{¶ 21} Fleischer also noted the liquidation of liabilities rule was "designed for an ongoing reimbursement system." (Tr. Vol. II at 301.) Because the General Assembly changed Ohio's Medicaid "reimbursement system legislatively" in 2004, "where they weren't going to use the cost report anymore," Fleischer asserted that the rules no longer "[made]

sense." (Tr. Vol. II at 301.) Fleischer affirmed that the "rules made sense prior to the change in legislation." (Tr. Vol. II at 301.)

{¶ 22} Hapchuk worked at the federal level as an auditor for the Medicare and Medicaid programs in the United States Department of Health and Human Services, Office of the Inspector General. Hapchuk noted that, although the PRM was "a Medicare manual," because Ohio had "deemed it in part of its hierarchy of criteria, it applies to Medicaid too." (Tr. Vol. IV at 484, 486-87.)

{¶ 23} Hapchuk explained that 42 C.F.R. 413.100 applied to "health care providers not subject to prospective payment[]" systems. (Tr. Vol. IV at 509.) Hapchuk noted that in the Medicare prospective payment system, "payment [was] not dependent upon what costs [providers] incur, it's dependent upon what type of services that they perform." (Tr. Vol. IV at 540.) Thus, Hapchuk stated the liquidation of liabilities rule did not apply in Ohio in 2003, because Ohio used "[a] prospective payment system" and had "moved away from the cost reimbursement to basically setting prices." (Tr. Vol. IV at 510.)

{¶ 24} The department called Julie Evers, the section chief for disability and aging policy at the department, to testify regarding the Ohio Medicaid reimbursement systems. Evers explained that Ohio used a "prospective cost-based system" of reimbursement from fiscal year 1994 to fiscal year 2005. (Tr. Vol. IV at 1009.) In the prospective cost-based system, the department used the costs reported in a facility's annual "cost report to establish a

prospective rate for the subsequent fiscal year," but did not "go back and reconcile it to what the provider actually spent in that period." (Tr. Vol. IV at 1009-11.) Thus, in the prospective cost-based system each facility received a unique per diem rate "based upon their actual costs" reported on their cost report. (Tr. Vol. IV at 1029-30.)

{¶ 25} Beginning on July 1, 2004, Ohio began to transition to a price-based prospective system. Under the price-based prospective system, the department paid "similarly-situated homes the same price subject to a case mix adjustment." (Tr. Vol. IV at 1034.) Nursing facilities continue to file calendar year cost reports under the price-based system, but the department uses the cost reports to "look[] to the peer group experience" rather than to establish a unique per diem rate. (Tr. Vol. IV at 1034.) Evers explained that the hierarchy of authority contained in Ohio Adm.Code 5101:3-3-01(A) applied to the cost reports filed under both the prospective cost-based system and the price-based prospective system.

{¶ 26} On February 22, 2013, the department filed a motion in limine to preclude CHS from offering evidence concerning unpaid patient days and other unpaid claims for service. The hearing examiner granted the department's motion in limine on March 15, 2013.

{¶ 27} At the phase two hearings, the department submitted exhibits containing reports of examination setting forth the department's adjustments to the patient days and patient liability amounts. The department relied on the reports of examination as

prima facie evidence to support its case in the days audits.

{¶ 28} On October 31, 2015, the hearing examiner issued a report and recommendation adopting the department's proposed adjustments under both the days audits and cost report audits. The hearing examiner concluded that the reports of examination depicting the department's adjustments to the patient days and patient liability amounts were prima facie evidence of those adjustments. As CHS failed to present evidence to "rebut [the department's] *prima facie* evidence with respect to patient days and patient liability adjustments," the hearing examiner concluded the department's adjustments in the days audits were correct. (Report & Recomm. at 12.)

{¶ 29} The hearing examiner observed that, although the C.F.R. and the PRM were regulations and interpretive guidelines "for Medicare cost reports," by including these materials in the hierarchy of authorities contained in Ohio.Adm Code 5101:3-3-01, "Ohio adopted these regulations to determine allowable costs for Medicaid cost reports in Ohio." (Report & Recomm. at 68.) Additionally, the hearing examiner noted that "[w]hether costs are allowable are determined by the law in effect at the time," such that "[a] future change in the reimbursement system [did] not provide justification to ignore the cost reporting laws in effect at the time of filing cost reports." (Report & Recomm. at 49.) As such, the hearing examiner concluded that the liquidation of liabilities rule contained in 42 C.F.R. 413.100 and PRM 2305 applied to the facilities' 2003 cost reports.

{¶ 30} As the "Strategic and Providers Choice Annual Services invoices and the Strategic and Providers Choice Enhanced Services invoices were due upon receipt," the hearing examiner held that the invoices were "short-term liabilities." (Report & Recomm. at 68.) Although most of the monthly invoices issued under the Annual Services portions of the contracts were liquidated within one year of the end of the 2003 cost reporting period, the hearing examiner noted several Annual Services invoices which were not allowable because they were not paid until 2005. The hearing examiner observed that "Terrace View Gardens, Franklin Ridge, Vandalia Park, Glen Meadows, and Wellington Manor paid the Strategic Annual Services December 2003 invoices by check dated March 2005," that "Carington Park paid the Strategic Annual Services November 2003 invoice by check dated March 2005 and the Strategic Annual Services December 2003 invoice by check dated April 2005," and that East Galbraith did not pay any of the 2003 Providers Choice Annual Services invoices until 2005. (Report & Recomm. at 64-65.)

{¶ 31} Regarding the promissory notes issued as payment for the Enhanced Services portions of the contracts, the hearing examiner observed that "none of the facilities' assets were transferred until 2005, over one year from the end of the 2003 cost report period." (Report & Recomm. at 23.) As such, the hearing examiner concluded the Enhanced Services costs were not allowable on the 2003 cost reports.

{¶ 32} The hearing examiner recommended that the department adopt the proposed audit adjustments and

order CHS to pay back to the department $11,111,557.96 in Medicaid provider overpayments.

{¶ 33} On October 3, 2016, the department issued an adjudication order adopting the hearing examiner's findings of fact, conclusions of law, and recommendations. CHS appealed the adjudication order to the common pleas court.

{¶ 34} On March 16, 2017, CHS filed a brief in the common pleas court. CHS asserted that the hearing examiner was unfairly biased in favor of the state, and that the department erred in applying the liquidation of liabilities rule to the consulting costs on the 2003 cost reports. CHS further asserted that the department committed reversible error by refusing to hear evidence concerning the unpaid days and unpaid claims, and by preventing CHS from rebutting the department's prima facie case in the days audits. The department filed a brief responding to CHS's arguments on May 9, 2017, and CHS filed a reply brief on May 30, 2017.

{¶ 35} On October 30, 2018, the common pleas court issued a decision and entry affirming in part and reversing in part the department's adjudication order. The court found no merit to CHS's contention that the hearing examiner was unfairly biased and "summarily reject[ed]" CHS's contention that it was "improperly foreclosed from seeking recovery for the 'unpaid days.'" (Decision at 2.) The court, however, agreed that the department erred in applying the liquidation of liabilities rule. In discussing the liquidation of liabilities rule, the court noted only the promissory notes issued as payment for the Strategic Enhanced

Services invoices; the court did not address Providers Choice or the Annual Services monthly invoices.

{¶ 36} The court observed that the department had followed the Ohio Adm.Code 5101:3-3-01(A) hierarchy of authorities "in applying Medicare's timely liquidation of liability rule set forth in 42 CFR 413.100 and §2305 of the Provider Reimbursement Manual." (Decision at 6.) However, the court concluded the department had "ignor[ed] the competent and credible evidence demonstrating that Medicare would not have applied the rule to the transaction at issue." (Decision at 8.) Specifically, the court noted that Hapchuk's testimony, the Federal Register, and *Abington Mem. Hosp. v. Burwell,* 216 F.Supp.3d 110 (D.D.C.2016), demonstrated that the liquidation of liabilities rule did not apply in the Medicare prospective payment system. As Ohio in 2003 reimbursed Medicaid providers on a prospective basis, the court concluded that the "liquidation of liabilities rule was not applicable to the costs at issue in 2003." (Decision at 10.) The court also "adopt[ed] and incorporate[d] in full the reasoning set forth in [CHS's] Reply Brief at pages 17 to 28" in reaching its conclusion. (Decision at 10.)

II. Assignments of Error

{¶ 37} The department assigns the following single assignment of error for our review on appeal:

> The lower court erred in concluding that the Department incorrectly construed and applied the liquidation-of-liabilities rule to disallow the consulting costs at issue.

{¶ 38} CHS cross-appeals, assigning the following four assignments of error for our review:

> [1.] Did [the department] deprive CHS of procedural due process by effectively failing to afford CHS a R.C. 119 hearing as required under federal and state law?
>
> [2.] Did [the department] improperly grant the motion in limine to exclude CHS from offering evidence on patient days when it offered several exhibits itself on patient days which the hearing officer mischaracterized as "prima facie evidence"?
>
> [3.] By cheating CHS out of patient days, did [the department] impermissibly shift costs to Medicare beneficiaries and other payers?
>
> [4.] By artificially lowering patient days for fiscal year 2003, is [the department] failing to observe fiscal responsibility given the resulting higher reimbursement rate to be applied to fiscal years 2004-2009?

III. Standard of Review

{¶ 39} In an administrative appeal pursuant to R.C. 119.12, the common pleas court must consider the entire record to determine whether reliable, probative, and substantial evidence supports the agency's order and whether the order is in accordance with law. *Univ. of Cincinnati v. Conrad,* 63 Ohio St.2d 108, 110-11 (1980). Reliable, probative, and substantial evidence has been defined as follows:

> (1) "Reliable" evidence is dependable; that is, it can be confidently trusted. In order to be reliable, there must be a reasonable probability that the evidence is true. (2) "Probative" evidence is evidence that tends to prove the issue in question; it must be relevant in determining the issue. (3) "Substantial" evidence is evidence with some weight; it must have importance and value.

Our Place, Inc. v. Ohio Liquor Control Comm., 63 Ohio St.3d 570, 571 (1992).

{¶ 40} The trial court's "review of the administrative record is neither a trial *de novo* nor an appeal on questions of law only, but a hybrid review in which the court 'must appraise all the evidence as to the credibility of the witnesses, the probative character of the evidence, and the weight thereof.'" *Lies v. Ohio Veterinary Med. Bd.,* 2 Ohio App.3d 204, 207 (1st Dist.1981), quoting *Andrews v. Bd. of Liquor Control,* 164 Ohio St. 275, 280 (1955). The trial court "must give due deference to the administrative resolution of evidentiary conflicts," although "the findings of the agency are by no means conclusive." *Conrad* at 111. The common pleas court conducts a de novo review of questions of law, exercising its independent judgment in determining whether the administrative order is "'in accordance with law.'" *Ohio Historical Soc. v. State Emp. Relations Bd.,* 66 Ohio St.3d 466, 471 (1993), citing R.C. 119.12.

{¶ 41} An appellate court's review of an administrative decision is more limited than that of the

common pleas court. *Pons v. Ohio State Med. Bd.,* 66 Ohio St.3d 619, 621 (1993). The appellate court is to determine only whether the common pleas court abused its discretion. *Id.*; *Lorain City Bd. of Edn. v. State Emp. Relations Bd.,* 40 Ohio St.3d 257, 261 (1988). The term "abuse of discretion" connotes more than an error of law or judgment; it implies that the court's attitude is unreasonable, arbitrary, or unconscionable. *Blakemore v. Blakemore,* 5 Ohio St.3d 217, 219 (1983). Absent an abuse of discretion, this court may not substitute its judgment for that of the administrative agency or the trial court. *Pons* at 621. However, on the question of whether the agency's order was in accordance with the law, this court's review is plenary. *Kistler v. Conrad,* 10th Dist. No. 04AP-1095, 2006-Ohio-3308, ¶ 9.

IV. Department's Appeal Proper Pursuant to R.C. 119.12(N)

{¶ 42} Initially, we address whether the department has the statutory authority to bring the present appeal. R.C. 119.12(N) provides for appeals from a common pleas court's ruling on an agency's order. R.C. 119.12(N) states:

> The judgment of the court shall be final and conclusive unless reversed, vacated, or modified on appeal. These appeals may be taken either by the party or the agency * * *. An appeal by the agency shall be taken on questions of law relating to the constitutionality, construction, or interpretation of statutes and rules of the agency, and, in the appeal, the court may also review and determine the correctness of the

> judgment of the court of common pleas that the order of the agency is not supported by any reliable, probative, and substantial evidence in the entire record.

{¶ 43} Thus, R.C. 119.12(N) "allows an agency the right to appeal only on questions of law pertaining to state statutes as well as rules and regulations which were promulgated by the agency." *Miller v. Dept. of Indus. Relations,* 17 Ohio St.3d 226, 226-27 (1985). *See Katz v. Dept. of Liquor Control,* 166 Ohio St. 229, 232 (1957). "Once the appeal is perfected on these grounds, the appellate court has jurisdiction to review the lower court's ruling as to the particular question of law and whether it is supported by any reliable, probative and substantial evidence." *Miller* at 227. "The key is that the trial court actually rule on a question of law that pertains to the constitutionality, construction or interpretation of a statute or agency rule." *Enertech Elec. v. W. Geauga Bd. of Edn.,* 10th Dist. No. 96AP-370 (Sept. 3, 1996).

{¶ 44} The common pleas court acknowledged that Ohio Adm.Code 5101:3-3-01(A) made 42 C.F.R. 413.100 and PRM 2305 applicable to the 2003 cost reports. However, the court held that neither rule applied to the consulting costs at issue on CHS's 2003 cost reports. The court's ruling effectively interpreted Ohio Adm.Code 5101:3-3-01(A) to mean that there were exceptions to the application of the rules identified in Ohio Adm.Code 5101:3-3-01(A). As the common pleas court's ruling interpreted Ohio Adm.Code 5101:3-3-01(A), the department may appeal the court's ruling pursuant to R.C. 119.12(N). *See Enertech Elec.*; *Tiggs*

v. Ohio Dept. of Job & Family Servs., 8th Dist. No. 106022, 2018-Ohio-3164, ¶ 17.

V. Department's Assignment of Error - The Liquidation of Liabilities Rule Applied to the 2003 Cost Reports

{¶ 45} The department's sole assignment of error asserts the common pleas court erred in concluding that the liquidation of liabilities rule did not apply to the consulting costs contained in CHS's 2003 cost reports.

{¶ 46} "Medicaid is a cooperative federal-state program through which the federal government provides financial assistance to states so that they may furnish medical care to needy individuals." *Drake Ctr. v. Dept. of Human Servs.,* 125 Ohio App.3d 678, 684 (10th Dist.1998), citing *Wilder v. Virginia Hosp. Assn.,* 496 U.S. 498 (1990), citing 42 U.S.C. 1396. States that choose to participate in Medicaid must comply with certain requirements imposed by the Medicaid Act and the regulations adopted by the Secretary of Health and Human Services ("Secretary"). *Id.,* citing *Wilder.* To qualify for federal assistance, a state is required to have an approved plan for medical assistance establishing a scheme for reimbursing participating health care providers. *Id.* at 685, citing *Wilder.*

{¶ 47} Thus, the administration of the Medicaid program "is left to the individual participating states according to a federally approved plan." *Morning View Care Ctr.-Fulton v. Ohio Dept. of Human Servs.,* 148 Ohio App.3d 518, 2002-Ohio-2878, ¶ 17 (10th Dist.). In contrast, Medicare is a "federal program that provides

health insurance to the elderly and disabled." *Baptist Med. Ctr. v. Burwell,* U.S.D.C.D.C. No. 11-cv-0899 (Feb. 28, 2019). *See Sun Towers, Inc. v. Heckler,* 725 F.2d 315, 318 (5th Cir.1984), citing 42 U.S.C. 1395c; *Natl. Fedn. of Indep. Business v. Sebelius,* 567 U.S. 519, 630 (2012) (observing that "Congress elected to nationalize health coverage for seniors through Medicare," and that it "could similarly have established Medicaid as an exclusively federal program" but did not, opting instead to "g[ive] the States the opportunity to partner in the [Medicaid] program's administration and development").

{¶ 48} To participate in the Medicaid program in Ohio, each facility subject to a provider agreement must file a cost report covering the calendar year or portion of the calendar year during which the facility participated in the Medicaid program. R.C. 5111.26(A)(1)(a); Ohio Adm.Code 5101:3-3-20; *St. Francis Home, Inc. v. Ohio Dept. of Job & Family Servs.,* 10th Dist. No. 06AP-287, 2006-Ohio-6147, ¶ 1. The costs included on a cost report must be "allowable," presented in accordance with "department rules," and must be "documented, reasonable, and related to patient care." R.C. 5111.27(B)(3); Ohio Adm.Code 5101:3-3-21(A)(2)(c).

{¶ 49} A cost is considered "reasonable" if it is "an actual cost that is appropriate and helpful to develop and maintain the operation of patient care facilities" and "does not exceed what a prudent buyer pays for a given item or services." Ohio Adm.Code 5101:3-3-01(AA). Ohio Adm.Code 5101:3-3-01(A) defines an allowable cost as "those costs incurred for certified beds

in a facility as determined by [the department] to be reasonable." Ohio Adm.Code 5101:3-3-01(A) further provides:

> Unless otherwise enumerated in Chapter 5101:3-3 of the Administrative Code, allowable costs are also determined in accordance with the following reference material, as currently issued and updated, in the following priority:
>
> (1) Title 42 Code of Federal Regulations (C.F.R.) Chapter IV;
>
> (2) The provider reimbursement manual ("health care financing administration HCFA Publication 15-1,"); or
>
> (3) Generally accepted accounting principles.

{¶ 50} Title 42 of the C.F.R. is the public health title; Chapter IV deals with the Centers for Medicare and Medicaid Services ("CMS"). The United States Department of Health and Human Services administers the Medicaid and Medicare programs through CMS. *Bellevue Hosp. Ctr. v. Leavitt,* 443 F.3d 163, 168 (2d Cir.2006).

{¶ 51} 42 C.F.R. 413.100, titled "[s]pecial treatment of certain accrued costs," is contained in the subchapter of Chapter IV applicable to Medicare.[8] 42 C.F.R.

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[8] In the portion of CHS's reply brief adopted by the trial court, CHS asserted that "presumably" only C.F.R. provisions "applicable to Medicaid" should apply to Ohio cost reports. (CHS's Trial Court Reply Brief at 17.) Ohio Adm.Code 5101:3-3-01(A) does not contain such a limitation, but rather cites generally to all of 42 C.F.R.

413.100 recognizes that "under the accrual basis of accounting, revenue is reported in the period in which it is earned and expenses are reported in the period in which they are incurred." 42 C.F.R. 413.100(a). 42 C.F.R. 413.100 alters the accrual basis of accounting principles for costs related to short-term liabilities, vacation pay, and all-inclusive paid days off, sick pay, compensation of owners, non-paid workers, and FICA and other payroll taxes. For these costs, "Medicare does not recognize the accrual of costs unless the related liabilities are liquidated timely." 42 C.F.R. 413.100(c)(1). Regarding short-term liabilities, 42 C.F.R. 413.100 provides that "a short-term liability, including the current portion of a long-term liability (for example, mortgage interest payments due to be paid in the current year), must be liquidated within 1 year after the end of the cost reporting period in which the liability is incurred." 42 C.F.R. 413.100(c)(2)(i)(A). 42 C.F.R. 413.100, however, does not define what "liquidation" means in the context of the rule.

{¶ 52} The PRM "contains interpretive guidelines for implementing federal Medicare * * * regulations. The manual, originally issued by the Health Care Financing Administration, is maintained by its successor, the Centers for Medicare and Medicaid Services." *Bryant Health Care* at ¶ 42. *See also Abraham Lincoln Mem. Hosp. v. Sebelius,* 698 F.3d 536, 542 (7th Cir.2012); *Dept. of Health* & *Mental*

Chapter IV. Notably, none of the Medicaid specific C.F.R. provisions that CHS cited to in its trial court reply brief address cost reporting. In contrast, 42 C.F.R. 413.100 specifically addresses cost reporting.

Hygiene v. Riverview Nursing Ctr., Inc., 104 Md.App. 593, 598 (1995), n.3 (noting the "PRM contains Medicare reimbursement guidelines * * * which elaborate upon the Medicare reimbursement regulations found in 42 C.F.R. Part 413"). PRM 2305, titled "Liquidation of Liabilities," mirrors 42 C.F.R. 413.100 and states that a "short term liability must be liquidated within 1 year after the end of the cost reporting period in which the liability is incurred." Section 2305 further provides:

> Liquidation must be made by check or other negotiable instrument, cash or legal transfer of assets such as stock, bonds, real property, etc. Where liquidation is made by check or other negotiable instrument, these forms of payment must be redeemed through an actual transfer of the provider's assets within the time limits specified in this section. Where the liability (1) is not liquidated within the 1-year time limit, or (2) does not qualify under the exceptions specified in §§ 2305.1 and 2305.2, the cost incurred for the related goods and services is not allowable in the cost reporting period when the liability is incurred, but is allowable in the cost reporting period when the liquidation of the liability occurs.

{¶ 53} PRM 2305.1 provides that if, within the one-year time limit, the provider furnishes to its fiscal intermediary[9] sufficient written justification for non-

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[9] Fiscal intermediaries in Medicare handle the "[d]ay-to-day administration of the Medicare program." *Highland Dist. Hosp. v.*

payment of the liability, the intermediary may grant an extension for good cause not to extend beyond three years. Section 2305.2 states that the liquidation of liabilities rule does not apply to PRM sections 220, 704.5, 2146.2, or the PRM sections which require liquidation within 75 days after the end of the cost reporting period. Neither exception applies in the present case.

{¶ 54} CHS asserts that the liquidation of liabilities rule, as stated in 42 C.F.R. 413.100 and PRM 2305, should not apply to the present case because the rule "is *not* an [Ohio Department of Medicaid] rule; it is a federal Medicare rule." (Emphasis sic.) (Appellee's Brief at 20.) Although 42 C.F.R. Chapter IV and the PRM are rules and interpretative guidelines applicable to Medicare cost reports, Ohio incorporated these rules into Ohio Adm.Code 5101:3-3-01(A) thereby making the liquidation of liabilities rule applicable to Ohio Medicaid cost reports.

{¶ 55} Notably, other jurisdictions routinely incorporate and apply federal Medicare guidelines to their state Medicaid programs. *See Heartland of*

Secretary of Health & Human Servs., 676 F.2d 230, 232 (1982). Fiscal intermediaries are "private non governmental entities," often times insurance companies, that "enter into contracts with Secretary, pursuant to the authority delegated by Congress in § 1395h, to serve as the Secretary's agent for various functions, including auditing provider cost reimbursement requests." *Id. Accord Regents of the Univ. of California v. Burwell,* 155 F.Supp.3d 31, 38 (D.C.C.2016) (noting that "fiscal intermediaries * * * act as the Secretary's agents"). Thus, a fiscal intermediary is simply an agent of the Secretary in the Medicare program.

Beckley WV, LLC v. Bureau for Med. Servs., Sup. Ct. of Appeals W.V. No. 15-0595 (Oct. 26, 2012) (noting the West Virginia Medicaid regulations provide that "federal Medicare statutes, regulations, and guidelines will be applied when federal and West Virginia Medicaid statutes, regulations, and guidelines are silent on a given point"); *In re McKerley Health Facilities,* 145 N.H. 164 (2000), quoting N.H. Admin. Rules, He-W 593.34 (providing that "'[d]ecisions governing the allowability of costs not specifically detailed'" under the New Hampshire Medicaid rules "'shall be pursuant to the Medicare Provider Reimbursement Manual'"); *Redding Med. Ctr. v. Bonta,* 75 Cal.App.4th 478, 484 (1999) (providing that allowable costs under the California Medicaid program are to "be determined based on the Medicare provisions of the Code of Federal Regulations and the PRM"); *Beverly Health & Rehab. Servs. v. Metcalf,* 24 Va.App. 584, 594-96 (1997) (same – Virginia); *Dept. of Health & Mental Hygiene* at 598 (same – Maryland); *Hampton Nursing Cntr. v. State Health & Human Serv. Finance Comm.*, 303 S.C. 143, 147 (1990) (same – South Carolina).

{¶ 56} The common pleas court concluded that the department ignored the evidence demonstrating that Medicare would not have applied the liquidation of liabilities rule to the consulting costs at issue. The record, however, demonstrates that the hearing examiner addressed and distinguished the evidence cited by the common pleas court.

{¶ 57} Hapchuk testified that the liquidation of liabilities rule could not apply to the 2003 cost reports

because Ohio utilized a prospective payment system. However, Hapchuk admitted that he was not familiar with Ohio's cost reporting system and affirmed that he did not know what was allowable on an Ohio Medicaid cost report. Hapchuk testified that he did "not understand exactly what they, Ohio, did on its prospective payment system," noting that he had "not been given an opportunity to take a look at it." (Tr. Vol. IV at 516.) The "only thing" Hapchuk reviewed to gain an understanding of Ohio's Medicaid reimbursement system was a one-page document he printed off from the internet. (Tr. Vol. IV at 546.) The one-page document stated, without further definition, that Ohio's Medicaid reimbursement systems were "[r]etrospective 1980-91, Semi-prospective 1991-93, Prospective 1993-2002, Pricing 2003-present." (State's Ex. 274.) Based on this document, Hapchuk stated that Ohio's Medicaid reimbursement system was a "pricing [reimbursement system] from 2003." (Tr. Vol.Nat 636.)

{¶ 58} Hapchuk explained that the Medicare prospective payment system did not depend on the costs a provider incurred, but rather depended on the services the provider performed. Hapchuk noted that if Ohio had "continued on cost reimbursement" and not "mov[ed] over to a prospective payment system" he would have said "okay, probably this rule applies." (Tr. Vol. IV at 514-15.) Notably, when counsel for the department explained that Ohio's prospective cost-based payment system used a provider's actual costs to set rates, Hapchuk acknowledged that such a system was "not a pure prospective payment system as the Medicare system is." (Tr. Vol. IV at 531.)

{¶ 59} The Federal Register addresses 42 C.F.R. 413.100 and explains that:

> Generally, under the Medicare program, health care providers not subject to prospective payment are paid for the reasonable costs of the covered items and services they furnish to Medicare beneficiaries. [42 C.F.R. 413.100] pertains to all services furnished by providers other than inpatient hospital services * * * and certain inpatient routine services furnished by skilled nursing facilities choosing to be paid on a prospective payment basis * * *.

60 Fed.Reg. 33126, effective June 27, 1995.

{¶ 60} *Abington Mem. Hosp.,* which the trial court also cited, follows the Federal Register and notes that 42 C.F.R. 413.100 "was explicitly made inapplicable to inpatient care that was subject to the [Medicare prospective payment system] payment scheme." *Id.* at 122. However, *Abington Mem. Hosp.* further explained that the Medicare prospective payment system "'relie[d] on prospectively fixed rates for each category of treatment rendered.'" *Id.* at 117, quoting *Methodist Hosp. of Sacramento v. Shalala,* 38 F.3d 1225, 1227 (D.C.Cir.1994). Thus, under the Medicare prospective payment system hospitals are "given advance notice of the pre-established rates at which inpatient services will be reimbursed," and hospitals are "reimbursed at those pre-set rates, irrespective of the costs the hospital actually incurs." *Id.* at 117. *Accord Atrium Med. Ctr. v. United States HHS,* 766 F.3d 560, 564 (6th Cir.2014); *Anna Jacques Hosp. v. Burwell,* 797 F.3d 1155 (D.C.Cir.2015). *See Community Care, L.L.C. v. Leavitt,*

477 F.Supp.2d 751, 754 (E.D.La.2007), quoting *New GWO Report Examines Medicare PPS Effects on Nursing Homes,* 8 No. 1 Cal. Health L. Monitor 4 (2000) (explaining that the Balanced Budget Act of 1997 made the Medicare prospective payment system, which is based on "'fixed, predetermined rates for each day of care,'" applicable to nursing facilities participating in the Medicare program).

{¶ 61} In contrast to the Medicare prospective payment system, Evers explained that Ohio's prospective cost-based system in 2003 used the actual costs reported on a facility's annual cost report to establish the facility's unique per diem rate for the subsequent fiscal year. Thus, while Ohio's reimbursement system was prospective, as it set a rate for a future period, it was also based on actual costs. *Accord Ohio Academy of Nursing Homes v. Ohio Dept. of Job & Family Servs.,* 114 Ohio St.3d 14, 2007-Ohio-2620, ¶ 2 (observing that "[u]nder a 'prospective payment' system that has been in place since 1993, Ohio reimburses a qualifying facility by paying it a per diem rate that is calculated based on the actual costs incurred by the facility in a prior period"); *Bryant Health Care Ctr.* at ¶ 5; *Arcadia Acres v. Ohio Dept. of Job & Family Servs.,* 10th Dist. No. 06AP-738, 2007-Ohio-6853, ¶ 2.

{¶ 62} The hearing examiner addressed Hapchuk's testimony and concluded that "[s]ince in Ohio, in 2003, the rates were based upon the reported costs incurred, not the type of service performed, Ohio was not under a prospective payment system such as that described by Mr. Hapchuk and used by Medicare." (Report &

Recomm. at 31.) Furthermore, the hearing examiner addressed the reliability issues present in Hapchuk's testimony, noting that "Hapchuk admitted he was not familiar with the rules applicable to Ohio's Medicaid cost reports" and that Hapchuk's understanding of Ohio's payment system came from a "one-page document from the internet." (Report & Recomm. at 30.)

{¶ 63} The hearing examiner also addressed the Federal Register's statement that 42 C.F.R. 413.100 did "not apply to Medicare providers under a prospective payment system." (Report & Recomm. at 43.) Again, because "providers in Ohio were reimbursed based upon costs incurred rather than services provided," the hearing examiner concluded that Ohio's prospective cost-based system differed from the Medicare prospective payment system. (Report & Recomm. at 43.) Based on the differences between the Medicare and Ohio Medicaid payment systems, the hearing examiner concluded that CHS's "argument that 42 CFR 413.100 and PRM 2305 [did] not apply to [the] 2003 cost reports based upon the reimbursement system in effect at the time [was] not well-taken." (Report & Recomm. at 43.)

{¶ 64} Accordingly, the department addressed the evidence demonstrating that the liquidation of liabilities rule did not apply to the Medicare prospective payment system. The department concluded that the liquidation of liabilities rule could apply in Ohio's prospective cost-based payment system because the system was based on reasonable costs rather than set prices. The common pleas court abused

its discretion by holding that the department had ignored the evidence concerning Medicare's application of the liquidation of liabilities rule.

{¶ 65} Furthermore, "the General Assembly created administrative bodies to facilitate certain areas of the law by placing the administration of those areas before boards or commissions composed of individuals who possess special expertise." *Parents Protecting Children v. Korleski,* 10th Dist. No. 09AP-48, 2009-Ohio-4549, ¶ 10, citing *Club 3000 v. Jones,* 10th Dist. No. 07AP-593, 2008-Ohio-5058, ¶ 29. Deference is afforded to an administrative agency's interpretation of its own rules and regulations if such an interpretation is consistent with statutory law and the plain language of the rule itself. *OPUS III-VII Corp. v. Ohio State Bd. of Pharmacy,* 109 Ohio App.3d 102, 113 (10th Dist.1996). *Accord Frisch's Restaurants, Inc. v. Ryan,* 121 Ohio St.3d 18, 2009-Ohio-2, ¶ 16; *Sierra Club v. Koncelik,* 10th Dist. No. 12AP-288, 2013-Ohio-2739, ¶ 24.

{¶ 66} We find that the department's conclusion that 42 C.F.R. 413.100 and PRM 2305 applied to the 2003 cost reports was entirely in keeping with and required by the plain language of Ohio Adm.Code 5101:3-3-01(A). As such, the department's conclusion that the liquidation of liabilities rule applied to the 2003 cost reports is correct.

{¶ 67} As the invoices issued under both the Annual Services and Enhanced Services portions of the Strategic and Providers Choice contracts were due

upon receipt, they were short-term liabilities.[10] Because the debts were short-term liabilities, Ohio Adm.Code 5101:3-3-01(A), 42 C.F.R. 413.100 and PRM 2305 required that the debts be liquidated within one year of the end of the 2003 cost reporting period for the costs to be allowable on the 2003 cost reports. As such, the costs associated with the Strategic and Providers Choice Annual Services monthly invoices which were issued in 2003, but not paid until 2005, were not allowable on the 2003 cost reports.

{¶ 68} The promissory notes the facilities issued to pay the Strategic and Providers Choice Enhanced Services invoices were negotiable instruments. As such, PRM 2305 provided that the notes had to be redeemed by an actual transfer of assets within one year of the end of the 2003 cost reporting period. *See Professional Rehab. Outpatient Servs. v. Health Care Fin. Admin.,* S.D.Tex. H-00-2526 (Dec. 6, 2001) (applying the liquidation of liabilities rule and concluding that, because a promissory note issued in 1995 was payable by "December 31, 1998 – three years following the end of the 1995 cost reporting period" the promissory note "did not meet this liquidation requirement"); *Med. Rehab. Servs., P.C. v. Bowen,* E.D. Mich. 87-CV-74547-DT (Sept. 6, 1989) (observing that pursuant to PRM 2305, "the issuance of [the] promissory note [was] not evidence of liquidation, unless plaintiff's assets were actually transferred to its creditor within one year of accrual").

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[10] Notably, in CHS's December 5, 2012 motion in limine, CHS acknowledged that the promissory notes were "used to satisfy the short term liabilities." (Dec. 5, 2012 Mot. in Limine at 8.)

{¶ 69} In the portion of CHS's reply brief adopted by the common pleas court, CHS asserted that the "promissory notes at issue were long-term liabilities, not subject to a Liquidation of Liabilities Rule." (CHS Trial Court Reply Brief at 20.) However, the promissory notes were issued as payment for the Enhanced Services invoices, which were short-term liabilities. The long-term nature of the promissory notes did not alter the fact that they were issued to pay short-term liabilities.

{¶ 70} While the presentation of a promissory note is sufficient to liquidate a debt for purposes of GAAP, the Medicare regulations which Ohio adopted in Ohio Adm.Code 5101:3-3-01(A) place additional requirements on this method of liquidation for cost reporting purposes. The Federal Register explains that while GAAP is "used to present the financial position of an organization," Medicare payment policy differs from GAAP as it seeks to "prevent the outlay of Federal trust funds before they are needed to pay the costs of providers' actual expenditures." 60 Fed.Reg. at 33129. Because a negotiable instrument does not cause an immediate transfer of assets, the Medicare regulations place additional requirements on negotiable instruments for cost reporting purposes.[11] Otherwise, providers could issue promissory notes and receive

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[11] Although the promissory notes at issue were negotiable instruments under R.C. 1303.03(A) (Uniform Commercial Code 3-104), the present case is concerned with the specific Ohio Medicaid cost reporting rules rather than general rules concerning negotiable instruments.

Medicare trust funds before ever expending their own assets.

{¶ 71} The requirements imposed by PRM 2305 applied to the promissory notes issued by the facilities to pay the Strategic and Providers Choice Enhanced Services invoices. Because the facilities did not transfer any assets as payments toward the promissory notes until 2005, beyond one year after the end of the 2003 cost reporting period, the costs associated with the Strategic and Providers Choice Enhanced Services invoices were not allowable on the facilities' 2003 cost reports.

{¶ 72} In the final analysis, Ohio Adm.Code 5101:3-3-01(A) plainly identifies 42 C.F.R. Chapter IV and the PRM as the reference materials to be used to determine whether costs reported on an Ohio Medicaid cost report are allowable. Those reference materials, at 42 C.F.R. 413.100 and PRM 2305, contain the liquidation of liabilities rule. The common pleas court ruled that the liquidation of liabilities rule did not apply to the facilities' 2003 cost reports because the rule would not apply in the Medicare prospective payment system. The department, however, distinguished the Medicare prospective payment system from the Ohio prospective cost-based system, and concluded that the liquidation of liabilities rule could apply in Ohio's prospective cost-based payment system. The common pleas court erred in reversing the portion of the department's adjudication order applying the liquidation of liabilities rule to the 2003 cost reports.

{¶ 73} Based on the foregoing, the department's sole assignment of error is sustained.

VI. First & Second Assignments of Error on Cross-Appeal – CHS Not Entitled to Introduce Evidence of Unpaid Days and Reports of Examination Were Prima Facie Evidence

{¶ 74} CHS's first assignment of error asserts the department deprived CHS of a R.C. Chapter 119 hearing. CHS asserts it did not receive a R.C. Chapter 119 hearing "on patient days since the Hearing Officer granted the Department's motion in limine" to exclude CHS's evidence of unpaid days and unpaid claims for service. (Cross-appellant's Brief at 21.) CHS's second assignment of error asserts that the hearing examiner erred in granting the department's motion in limine and in characterizing the department's exhibits as prima facie evidence. As CHS's first and second assignments of error are related, we address them jointly.

{¶ 75} The hearing examiner had the authority to admit or exclude evidence at the administrative hearing. Our review is limited to determining whether the common pleas court abused its discretion by failing to reverse the hearing examiner's evidentiary ruling. *HCMC, Inc. v. Ohio Dept. of Job & Family Servs.,* 179 Ohio App.3d 707, 2008-Ohio-6223, ¶ 57.

{¶ 76} In granting the department's motion to exclude the evidence of unpaid days and unpaid claims for service, the hearing examiner observed that R.C. 5111.06 authorized R.C. Chapter 119 hearings "for providers to challenge matters included in final fiscal audits, which examine payments made to providers." (Mar. 15, 2013 Journal Entry at 4.) As an audit

examines payments made to providers, the hearing examiner concluded that "adjudication of claims for unpaid days and unpaid claims [were] not at issue in this administrative hearing." (Mar. 15, 2013 Journal Entry at 4.)

{¶ 77} "[A]bsent specific statutory or constitutional authority, a party has no inherent right to appeal from an order of an administrative agency." *Springfield Fireworks, Inc. v. Ohio Dept. of Commerce,* 10th Dist. No. 03AP-330, 2003-Ohio-6940, ¶ 17. *Accord* Section 4, Article IV, Ohio Constitution. R.C. 5111.06(B) provides:

> The department shall do either of the following by issuing an order pursuant to an adjudication conducted in accordance with Chapter 119 of the Revised Code:
>
> (1) Enter into or refuse to enter into a provider agreement with a provider, or suspend, terminate, renew, or refuse to renew an existing provider agreement with a provider;
>
> (2) Take any action based upon a final fiscal audit of a provider.

{¶ 78} If a party is adversely affected by an order issued under R.C. 5111.06(B), the party may "appeal to the court of common pleas of Franklin county in accordance with section 119.12 of the Revised Code." R.C. 5111.06(C). Thus, a party has R.C. Chapter 119 appeal right from any action the department takes based on a final fiscal audit. *Clifton Care Ctr.* at ¶ 12. An "audit" is defined as "a formal postpayment examination * * * of a Medicaid provider's records and documentation to determine program compliance, the

extent and validity of services paid for under the Medicaid program and to identify any inappropriate payments." Ohio Adm.Code 5101:3-1-27(B)(1). Thus, an audit reviews payment made to "determine the amount of overpayment." Ohio Adm.Code 5101:3-1-27(B)(1).

{¶ 79} Accordingly, as an audit reviews payments, unpaid days and unpaid claims for service are not reviewed by the department in an audit. *See Clifton Care Ctr.* at ¶ 17 (observing that "[s]ince [the department] never paid the claims at issue, it could not audit them"). Accordingly, CHS had no right under R.C. 5111.06 to address the unpaid days and unpaid claims at the R.C. Chapter 119 hearing on the final fiscal audits.[12]

{¶ 80} CHS asserts that the R.C. Chapter 119 hearing was the only opportunity CHS had to address its claims relating to the unpaid days and unpaid

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[12] CHS asserts that it was entitled to present evidence on the unpaid days and unpaid claims because in *Ohio Academy of Nursing Homes, Inc. v. Ohio Dept. of Job & Fam. Servs.,* 149 Ohio App.3d 413, 2002-Ohio-4721 (10th Dist.), this court "ruled the department must adjudicate all issues at once in a final fiscal audit pursuant to R.C. 5111.06(B)." (Cross-appellant's Brief at 22.) In *Ohio Academy of Nursing Home,* the court held that for a R.C. Chapter 119 hearing to occur pursuant to R.C. 5111.06, "'there must have been a final fiscal audit, which impliedly means that all issues for the reimbursement period have been adjudicated.'" *Id.* at ¶ 25, quoting trial court decision. The statement in *Ohio Academy of Nursing Homes* meant that all issues pertaining to the audit had to be adjudicated during the reimbursement period. The statement did not indicate that a facility could introduce any issue unrelated to the audit at a R.C. Chapter 119 hearing on a final fiscal audit.

claims. However, Ohio Adm.Code 5101:3-1-57(B) provides that "[o]ther administrative actions affecting the provider's Medicaid program status which are not subject to hearings under Chapter 119 of the Revised Code, may be reconsidered by the deputy director in the office where the contestation arose." Notably, "denied claims and claim adjustments which may be reconsidered" pursuant to Ohio Adm.Code 5101:3-1-57(B), are expressly identified as "[a]ctions that do not provide [R.C. Chapter 119] hearing rights." Ohio Adm.Code 5101:6-50-01(C)(9).

{¶ 81} Furthermore, "when an agency's decision is discretionary and, by statute, not subject to direct appeal, a writ of mandamus is the sole vehicle to challenge the decision." *Ohio Academy of Nursing Homes v. Ohio Dept. of Job & Family Servs.,* 114 Ohio St.3d 14, 2007-Ohio-2620, ¶ 23. *Accord State ex rel. Potts v. Comm. on Continuing Legal Edn.,* 93 Ohio St.3d 452, 457 (2001) (providing that "[m]andamus is the appropriate remedy where no right of appeal is provided to correct an abuse of discretion by a public body"); *Heartland Jockey Club, Ltd. v. Ohio State Racing Comm.*, 10th Dist. No. 98AP-1465 (Aug. 3, 1999). To the extent CHS contends that the department has yet to deny or otherwise act on its claims for payment, a writ of mandamus is the proper vehicle to compel an agency to act. *State ex rel. GMC v. Indus. Comm.*, 117 Ohio St.3d 480, 2008-Ohio-1593, ¶ 9, citing *State ex rel. Levin v. Schremp,* 73 Ohio St.3d 733, 735 (1995) (holding that "[a] mandamus action is thus appropriate where there is a legal basis to compel a public entity to perform its duties under the law"); *Morning View Care Ctr.-Fulton* at ¶ 16.

{¶ 82} CHS asserts that when the department "offered testimony on its four exhibits as to patient days" the department "waived the prima facie presumption" for those exhibits. (Cross-appellant's Brief at 29.) The department initially introduced the reports of examination detailing the department's adjustments to the patient days and patient liability amounts as exhibits at the January 22, 2013 hearing. The department noted that it was relying on the exhibits as its prima facie case in the days audits. At the April 8, 2013 hearing, the department introduced four exhibits to replace four of the exhibits previously introduced at the January 22, 2013 hearing. The four revised exhibits cleared some of the department's prior adjustments to patient days. The department submitted the replacement exhibits as prima facie evidence of its adjustments to the patient days.

{¶ 83} CHS objected that the revised exhibits were unauthenticated. As such, the department presented Kierstyn Canter, an audit manager at the department, to authenticate the exhibits. Canter stated the four exhibits were created under her supervision and were all kept in the ordinary course of the department's business. CHS asserts that Canter's testimony waived the prima facie presumption on the four exhibits.

{¶ 84} Ohio Adm. Code 5101:6-50-09(A)(4) provides that "[a]ny audit report, report of examination, exit conference report, or report of final settlement issued by [the department] and entered into evidence is to be considered *prima facie* evidence of what it asserts." "Prima facie evidence has been defined as that which is 'sufficient to support but not to compel a certain

conclusion and does no more than furnish evidence to be considered and weighed but not necessarily accepted by the trier of the facts.'" *Meadowwood Nursing Facility v. Ohio Dept. of Job & Family Servs.,* 10th Dist. No. 04AP-732, 2005-Ohio-1263, ¶ 14, quoting *Cleveland v. Keah,* 157 Ohio St. 331, 337 (1952).

{¶ 85} "The presentation of evidence on some audit findings [does] not deprive [the department] of all applicable presumptions" under Ohio Adm.Code 5101:6-50-09(A)(4). *Id.* at ¶ 13. "However, to the extent that the witness testifies with respect to discernible audit factors, then the presumption [in Ohio Adm.Code 5101:6-50-09(A)(4)] has no effect." *Id.* As Canter simply authenticated the exhibits and did not testify regarding any discernable audit factors, Canter's testimony did not invalidate the prima facie presumption on the four exhibits.

{¶ 86} CHS contends that "[b]y granting the motion in limine, the Department precluded CHS from offering evidence on patient days." (Cross-appellant's Brief at 4.) However, the hearing examiner's ruling on the motion in limine only prevented CHS from introducing evidence on unpaid days and unpaid claims. The hearing examiner's ruling did not prevent CHS from presenting evidence on the patient days at issue in the audit or from rebutting the department's prima facie evidence.

{¶ 87} The trial court did not abuse its discretion by failing to reverse the hearing examiner's evidentiary ruling on the unpaid days and unpaid claims or in upholding the department's adjustments in the days

audits. CHS's first and second assignments of error on cross-appeal are overruled.

VII. Third & Fourth Assignments of Error on Cross-Appeal – Not Raised in Common Pleas Court

{¶ 88} CHS's third assignment of error asserts the department impermissibly shifted costs to Medicare beneficiaries and to other payers. CHS's fourth assignment of error asserts the department failed to observe fiscal responsibility by failing to pay CHS for the unpaid patient days in fiscal year 2003.

{¶ 89} CHS did not raise either argument contained in its third or fourth assignments of error in the common pleas court. CHS's failure to raise these arguments in the common pleas court forfeits these issues for appellate purposes. *Edmands v. State Med. Bd.,* 10th Dist. No. 16AP-726, 2017-Ohio-8215, ¶ 14. *Accord Nunn v. Ohio Dept. of Ins.,* 10th Dist. No. 18AP-114, 2018-Ohio-4030, ¶ 11 (noting that "[i]t is well established that a party may not present new arguments for the first time on appeal"). As CHS has forfeited these arguments, we overrule CHS's third and fourth assignments of error on cross-appeal. *Parker's Tavern v. Ohio Dept. of Health,* 195 Ohio App.3d 22, 2011-Ohio-3598, ¶ 11 (10th Dist.).

VIII. Conclusion

{¶ 90} Having sustained the department's sole assignment of error, CHS's four assignments of error on cross-appeal are overruled, we reverse in part and affirm in part the judgment of the Franklin County Court of Common Pleas.

Judgment affirmed in part, reversed in part, case remanded.

BRUNNER and NELSON JJ., concur.

IN THE COURT OF APPEALS OF OHIO
TENTH APPELLATE DISTRICT

No. 18AP-897
(C.P.C. No. 16CV-9766)

(REGULAR CALENDAR)

CHS-Lake Erie, Inc. et al.,	)
	)
Appellants-Appellees/	)
Cross-Appellants,	)
	)
v.	)
	)
Ohio Department of Medicaid,	)
	)
Appellee-Appellant/	)
Cross-Appellee.	)
	)

JUDGMENT ENTRY

For the reasons stated in the decision of this court rendered herein on February 13, 2020, appellant/cross-appellee's sole assignment of error is sustained, appellees/cross-appellant's four assignments of error are overruled, and we reverse in part and affirm in part the judgment of the Franklin County Court of Common Pleas. Any outstanding appellant court costs are assessed to appellant.

BEATTY BLUNT, J., BRUNNER & NELSON, JJ.

By /S/ JUDGE
Judge Laurel Beatty Blunt

Tenth District Court of Appeals

Date:	02-18-2020
Case Title:	CHS-LAKE ERIE INC ET AL -VS- OHIO DEPARTMENT MEDICAID
Case Number:	18AP000897
Type:	JEJ - JUDGMENT ENTRY

So Ordered

/s/ Judge Laurel Beatty Blunt

IN THE COURT OF APPEALS OF OHIO
TENTH APPELLATE DISTRICT

No. 18AP-897
(C.P.C. No. 16CV-9766)

(REGULAR CALENDAR)

CHS-Lake Erie, Inc. et al.,	)
	)
Appellants-Appellees/	)
Cross-Appellants,	)
	)
v.	)
	)
Ohio Department of Medicaid,	)
	)
Appellee-Appellant/	)
Cross-Appellee.	)
	)

MEMORANDUM DECISION

Rendered on October 22, 2020

On brief: *Webster* & *Associates, Co., LPA,* and *Geoffrey E. Webster,* for appellees/cross-appellants.

On brief: *Dave Yost,* Attorney General, and *Rebecca L. Thomas,* for appellant/cross-appellee.

ON APPLICATION FOR RECONSIDERATION
ON APPLICATION FOR CONSIDERATION
EN BANC ON MOTIONS

BEATTY BLUNT, J.

{¶ 1} Appellants-appellees/cross-appellants, CHS-Glenwell, Inc. (dba Glen Meadows), CHS-Glenwell, Inc. (dba Wellington Manor), CHS-Greater Cincinnati, Inc. (dba East Galbraith Health Care Center), CHS-Lake Erie, Inc. (dba Carington Park), CHS-Miami Valley, Inc. (dba Vandalia Park), CHS-Miami Valley, Inc. (dba Franklin Ridge), and CHS-Ohio Valley, Inc. (dba Terrace View Gardens) (collectively, "CHS") have filed timely applications seeking reconsideration, pursuant to App.R. 26(A)(1), and consideration en banc, pursuant to App.R. 26(A)(2), of this court's decision in *CHS-Lake Erie, Inc. v. Ohio Dept. of Medicaid,* 10th Dist. No. 18AP-897, 2020-Ohio-505. Appellee-appellant/cross-appellee, the Ohio Department of Medicaid (the "department"), opposes CHS's applications. For the reasons which follow, we deny CHS's applications for reconsideration and consideration en banc.

I. Procedural Matters: CHS's Motion to Convert and Motion to Exceed Page Limitation Granted

{¶ 2} Initially, we must resolve two pending motions concerning CHS's post-decision filings. This court rendered its decision in *CHS-Lake Erie* on February 13, 2020 and issued the judgment entry corresponding to the decision on February 18, 2020. On February 24, 2020, CHS filed a combined application for reconsideration and consideration en banc and a separate motion to certify a conflict. Although CHS's combined application for reconsideration and consideration en banc contained an argument to support CHS's request for reconsideration, CHS did not

present an argument to support its request for consideration en banc. CHS's motion to certify a conflict asserted that our decision in *CHS-Lake Erie* conflicted with the following two decisions rendered by this court: *Meadowbrook Care Ctr. v. Ohio Dept. of Job & Family Servs.,* 10th Dist. No. 06AP-871, 2007-Ohio-6534, and *OMG MSTR LSCO, LLC v. Ohio Dept. of Medicaid,* 10th Dist. No. 18AP-223, 2018-Ohio-4843.

{¶ 3} On March 5, 2020, the department filed memoranda in opposition to CHS's motion to certify a conflict and CHS's combined application for reconsideration and consideration en banc. The department asserted this court should deny CHS's motion to certify a conflict as CHS failed to allege a conflict between *CHS-Lake Erie* and a decision from another court of appeals of this state. Although the department noted that CHS failed to present an argument to support its request for consideration en banc, the department also asserted there was no conflict of law between *CHS-Lake Erie* and either *Meadowbrook Care Ctr.* or *OMG MSTR LSCO, LLC.*

{¶ 4} On March 10, 2020, CHS filed a combined motion asking this court to convert its motion to certify a conflict to an application for consideration en banc and for leave to file an over length application for consideration en banc instanter. CHS acknowledged the alleged "conflict in the holdings does indeed exist within the Tenth Appellate District as opposed to a conflict in opinions issued by different districts," and asserted the arguments contained in its motion to certify a conflict "would have been appropriately

contained in an application for en banc consideration." (Appellees/Cross-Appellants' Mot. to Convert at 3.)

{¶ 5} To certify a conflict between cases, "the certifying court must find that its judgment is in conflict with the judgment of a court of appeals of another district." *Whitelock v. Gilbane Bldg. Co.*, 66 Ohio St.3d 594, 596 (1993). *Accord* App.R. 25(A). The "procedure for certified conflicts does not apply to conflicts existing within an appellate district." *In re J.J.,* 111 Ohio St.3d 205, 2006-Ohio-5484, paragraph three of the syllabus. As CHS never asserted the judgment in *CHS-Lake Erie* conflicted with the judgment of a court of appeals of another district, CHS never even raised a potential issue for certification. In contrast, the purpose of an en banc proceeding is to resolve conflicts of law that arise within an appellate district. App.R. 26(A)(2)(a); *McFadden v. Cleveland State Univ.,* 120 Ohio St.3d 54, 2008-Ohio-4914, ¶ 10, 15-16.

{¶ 6} Accordingly, in the interests of justice, we grant CHS's motion to convert its motion to certify a conflict to an application for consideration en banc and find that CHS has withdrawn its motion to certify a conflict. We also grant CHS's motion for leave to exceed the page limitation on its application for consideration en banc.

II. Application for Reconsideration Denied

{¶ 7} When presented with an application for reconsideration filed pursuant to App.R. 26, an appellate court must determine whether the application "calls to the attention of the court an

obvious error in its decision, or raises an issue for consideration that was either not considered at all or was not fully considered by the court when it should have been." *Columbus v. Hodge,* 37 Ohio App.3d 68 (10th Dist.1987), paragraph one of the syllabus. "'App.R. 26 provides a mechanism by which a party may prevent miscarriages of justice that could arise when an appellate court makes an obvious error or renders an unsupportable decision under the law.'" *Huff v. Ohio State Racing Comm.,* 10th Dist. No. 15AP-586, 2017-Ohio-948, ¶ 2, quoting *State v. Owens,* 112 Ohio App.3d 334, 336 (nth Dist.1996).

{¶ 8} However, an appellate court will not grant "[a]n application for reconsideration * * * just because a party disagrees with the logic or conclusions of the appellate court." *Bae v. Dragoo & Assocs., Inc.,* 10th Dist. No. 03AP-254, 2004-Ohio-1297, ¶ 2. "Furthermore, an application for reconsideration is not a means to raise new arguments or issues." *Electronic Classroom of Tomorrow v. State Bd. of Edn.,* 10th Dist. No. 17AP-767, 2019-Ohio-1540, ¶ 3, citing *State v. Wellington,* 7th Dist. No. 14 MA 115, 2015-Ohio-2095, ¶ 9.

{¶ 9} In *CHS-Lake Erie,* this court addressed the department's appeal and CHS's cross-appeal from the common pleas court's order reversing in part and affirming in part the department's adjudication order. The department's adjudication order concluded that CHS owed the department $11,111,557.96 in Medicaid provider overpayments. The overpayment finding was the result of two types of audits: cost report audits of the CHS facilities' calendar year 2003 cost reports and

days audits of the days the facilities were paid for rendering services to Medicaid recipients between 2003 and 2006. The primary issue in the direct appeal concerned the department's application of the liquidation of liabilities rule to the CHS facilities' 2003 cost reports.

{¶ 10} The liquidation of liabilities rule is contained in 42 C.F.R. 413.100 and the provider reimbursement manual ("PRM") section 2305. Ohio Adm.Code 5101:3-3-01(A) provides that allowable costs for Medicaid cost reporting purposes are to be determined according to the following reference material in the following priority: (1) Title 42 C.F.R. Chapter IV, (2) the PRM, or (3) generally accepted accounting principles ("GAAP"). "Although 42 C.F.R. Chapter IV and the PRM are rules and interpretative guidelines applicable to Medicare cost reports, Ohio incorporated these rules into Ohio Adm.Code 5101:3-3-01(A) thereby making the liquidation of liabilities rule applicable to Ohio Medicaid cost reports." *CHS-Lake Erie* at ¶ 54. 42 C.F.R. 413.100 provides that "a short term liability * * * must be liquidated within 1 year after the end of the cost reporting period in which the liability is incurred." 42 C.F.R. 413.100(c)(2)(i)(A). PRM section 2305 provides that if the liquidation of a short-term liability "is made by check or other negotiable instrument, these forms of payment must be redeemed through an actual transfer of the provider's assets within the" one-year time limit.

{¶ 11} The costs at issue in *CHS-Lake Erie* were certain consulting costs the CHS facilities incurred in 2003. The consulting costs were short-term liabilities,

and the facilities failed to timely liquidate the consulting costs pursuant to the requirements of 42 C.F.R. 413.100 and PRM section 2305. As such, the department disallowed the relevant consulting costs from the facilities' 2003 cost reports. In *CHS-Lake Erie,* we found the department correctly applied the liquidation of liabilities rule to the consulting costs. *Id.* at ¶ 66.

{¶ 12} The common pleas court reversed the department's application of the liquidation of liabilities rule based on the court's conclusion that the "department had 'ignor[ed] the competent and credible evidence demonstrating that Medicare would not have applied the rule to the transaction at issue.'" *CHS-Lake Erie* at ¶ 36, quoting Trial Court Decision at 8. Ohio's Medicaid reimbursement system in 2003 was a prospective cost-based system of reimbursement. In the prospective cost-based system, the department used the actual costs reported on a facility's cost report to establish a unique per diem rate for the facility for the subsequent fiscal year. *Id.* at ¶ 24. In contrast, the Medicare prospective payment system relied on prospectively fixed rates for each category of treatment rendered. *Id.* at ¶ 60. The Federal Register explains that 42 C.F.R. 413.100 "pertains to all services furnished by providers" in the Medicare system other than services paid for "on a prospective payment basis." *Id.* at ¶ 59. John Hapchuk, a former auditor for the Medicare and Medicaid programs in the United States Department of Health and Human Services, testified at the department hearings that the liquidation of liabilities rule did not apply in Ohio in 2003 because Ohio used "[a] prospective payment system" like the

Medicare prospective payment system and "had moved away from the cost reimbursement to basically setting prices." *Id.* at ¶ 23.

{¶ 13} In *CHS-Lake Erie,* we observed that the department's hearing examiner had addressed both Hapchuk's and the Federal Register's statements indicating the liquidation of liabilities rule did not apply in the Medicare prospective payment system. *Id.* at ¶ 62-63. The hearing examiner concluded that because "providers in Ohio were reimbursed based upon costs incurred rather than services provided, * * * Ohio's prospective cost-based system differed from the Medicare prospective payment system." *Id.* at ¶ 63. The hearing examiner also noted the "reliability issues present in Hapchuk's testimony," as Hapchuk "admitted he was not familiar with the rules applicable to Ohio's Medicaid cost reports." *Id.* at ¶ 62. As the department had addressed and distinguished the evidence demonstrating that Medicare would not apply the liquidation of liabilities rule in the Medicare prospective payment system, we concluded in *CHS-Lake Erie* that the common pleas court "abused its discretion by holding that the department had ignored the evidence concerning Medicare's application of the liquidation of liabilities rule." *Id.* at ¶ 64. Accordingly, CHS's contention that *CHS-Lake Erie* contains "no discussion on how the common pleas decision was 'unreasonable, arbitrary, or unconscionable'" lacks merit. (Appellees/Cross-Appellants' App. for Recon. at 8.)

{¶ 14} CHS asserts in its application for reconsideration that the liquidation of liabilities rule

"cannot be applied in a prospective [payment] system," whether the prospective payment system is "based on past costs or a fixed or negotiated rate." (Appellees/Cross-Appellants' App. for Recon. at 4.) To support its assertion, CHS cites to various provisions of 42 C.F.R. 413 which demonstrate that Medicare has a retrospective system of cost reimbursement for providers who are not subject to the Medicare prospective payment system. (Appellees/Cross-Appellants' App. for Recon. at 3, 6-7, 13.) *See* 42 C.F.R. 413.1(b) (noting that "[e]xcept as provided" in the paragraphs addressing the prospective payment system, Medicare will pay for services furnished by its providers on the "basis of reasonable costs"); 42 C.F.R. 413.5 (stating general principles of Medicare retrospective cost reimbursement); 42 C.F.R. 413.60 (detailing how the Medicare fiscal contractors will make payments to providers under the retrospective payment system). *Compare* 42 C.F.R. 413.1(d)(2) (noting that Medicare payments for inpatient hospital services after October 1, 1983 "are determined prospectively on a per discharge basis"); 42 C.F.R. 413.1(g)(2)(i) (noting that the amount "paid" by Medicare for services furnished in a nursing facility "on or after July 1, 1998, * * * is determined in accordance with the prospectively determined payment rates").

{¶ 15} The fact that Medicare retained its retrospective payment system for providers not subject to the Medicare prospective payment system does not demonstrate that the liquidation of liabilities rule could not apply in Ohio's prospective cost-based payment system. Under Ohio's prospective cost-based system, the department used the actual costs reported on a

facility's annual cost report to establish a prospective per diem rate for the facility for the subsequent fiscal year. *CHS-Lake Erie* at ¶ 24. Unlike the Ohio prospective cost-based system, the Medicare prospective payment system utilizes only pre-set rates of payment and does not consider the actual costs incurred by the provider. *Accord Anna Jacques Hosp. v Burwell,* 797 F.3d 1155, 1157-58 (D.C.Cir.2015) (explaining that the Medicare "Prospective Payment System reimburses hospitals for medical care * * * on the basis of a pre-established formula, regardless of the actual costs incurred by the hospital"); *Abington Mem. Hosp. v. Burwell,* 216 F.Supp.3d 110, 117 (D.C.Cir.2016) (noting that in the Medicare prospective payment system hospitals are "given advance notice of the pre-established rates at which inpatient services will be reimbursed," and hospitals are "reimbursed at those pre-set rates, irrespective of the costs the hospital actually incurs"). Accordingly, the statements contained in the Federal Register and case law demonstrating that the liquidation of liabilities rule does not apply in the Medicare prospective payment system demonstrate only that the rule does not apply in a prospective payment system based on pre-set rates. CHS fails to cite any authority demonstrating that the liquidation of liabilities rule did not apply in Ohio's prospective cost-based system of reimbursement.

{¶ 16} CHS contends the testimony from Hapchuk, Bert Cummins, and John Fleischer was "reliable, probative, and substantial" evidence demonstrating it was "not possible to apply the Liquidation of Liabilities Rule to a prospective payment system." (Appellees/ Cross Appellants' App. for Recon. at 15.) We addressed

Hapchuk, Cummins, and Fleischer's testimonies in *CHS-Lake Erie*.

{¶ 17} Hapchuk's testimony was not reliable. Indeed, Hapchuk admitted he was not familiar with Ohio's Medicaid reimbursement system and mistakenly stated that Ohio utilized a pricing system in 2003. *CHS-Lake Erie* at ¶ 57-58. Although Cummins testified that the liquidation of liabilities rule could not apply in a "prospective system," he stated the liquidation of liabilities rule did apply "in a cost-based or reasonable cost system." (Tr. Vol. VI at 748.) Ohio's Medicaid payment system in 2003 was a cost-based system. Fleischer testified that the liquidation of liabilities rule "no longer [made] sense" because Ohio changed its Medicaid reimbursement system in 2004, but affirmed "that the rules made sense prior to the change in legislation." *CHS-Lake Erie* at ¶ 21. Thus, Fleischer affirmed the liquidation of liabilities rule made sense in Ohio in 2003.

{¶ 18} CHS asserts that certain acts of the General Assembly which altered the Medicaid reimbursement system in Ohio for fiscal years 2006, 2007, 2008, and 2009 demonstrate that the "Liquidation of Liabilities Rule may not be applied" in the present case. (Appellees/Cross-Appellants' App. for Recon. at 10.) In *CHS-Lake Erie,* we recognized that the General Assembly changed Ohio's Medicaid payment system beginning on July 1, 2004, when Ohio began to transition to a price-based prospective payment system. *Id.* at ¶ 25. However, *CHS-Lake Erie* concerned the costs reported on the facilities' 2003 cost reports. As such, the legislative changes to Ohio's Medicaid

reimbursement system after 2003 were not relevant to determining whether the costs reported on the facilities' 2003 cost reports were allowable.

{¶ 19} CHS notes that 2004 Am.Sub.H.B. No. 95 was "in effect in 2003." (Appellees/Cross-Appellants' App. for Recon. at 10.) 2004 Am.Sub.H.B. No. 95 established rate caps on the per diem rates Medicaid facilities would receive in fiscal years 2004 and 2005. *See* 2004 Am.Sub.H.B. No. 95, Section 59.37(B)(1) and (2).[1] The department used the costs reported on the facilities' calendar year 2003 cost reports to establish the facilities' per diem rates for fiscal year 2005. *CHS-Lake Erie* at ¶ 6. Testimony at the agency hearings demonstrated the facilities' fiscal year 2005 per diem rates were "subject to ceilings." (Tr. Vol. VIII at 1009.) However, the fact that rate caps or ceilings would be applied to the CHS facilities' fiscal year 2005 per diem rates did not render the liquidation of liabilities rule inapplicable to the facilities' 2003 cost reports.

{¶ 20} The CHS facilities paid a portion of the consulting costs at issue in *CHS-Lake Erie* by issuing promissory notes. The facilities issued the promissory notes on December 31, 2003, and pursuant to the terms of the notes did not make payments on the notes until 2005. *CHS-Lake Erie* at ¶ 13. As the payments on the promissory notes did not occur until over one year after the end of the 2003 cost reporting period, the liquidation of liabilities rule mandated that the costs associated with the promissory notes "were not

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[1] Accessible at http://archives.legislature.state.oh.us/BillText125/125_HB_95_EN2_N.html

allowable on the facilities' 2003 cost reports." *Id.* at ¶ 71.

{¶ 21} CHS contends that "[u]nder Ohio's Uniform Commercial Code" the promissory notes amounted to "payment in full" of the consulting costs at issue. (Appellees/Cross-Appellants' App. for Recon. at 18-19.) As we explained in *CHS-Lake Erie*, "[a]lthough the promissory notes at issue were negotiable instruments under R.C. 1303.03(A) (Uniform Commercial Code 3-104), the present case is concerned with the specific Ohio Medicaid cost reporting rules rather than general rules concerning negotiable instruments." *Id.* at ¶ 70, fn. 11. Thus, while "the presentation of a promissory note is sufficient to liquidate a debt for purposes of GAAP, the Medicare regulations which Ohio adopted in Ohio Adm.Code 5101:3-3-01(A) place additional requirements on this method of liquidation for cost reporting purposes." *Id.* at ¶ 70.

{¶ 22} CHS contends the department's interpretation of 42 C.F.R. 413.100 and PRM section 2305 was not entitled to deference because the "Liquidation of Liabilities Rule is *not* an ODM rule; it is a federal Medicare rule." (Emphasis sic.) (Appellees/Cross-Appellants' App. for Recon. at 14.) However, Ohio incorporated 42 C.F.R. 413.100 and PRM section 2305 into Ohio Adm.Code 5101:3-3-01(A), "thereby making the liquidation of liabilities rule applicable to Ohio Medicaid cost reports." *Id.* at ¶ 54. And what we correctly held was that "the department's conclusion that 42 C.F.R. 413.100 and PRM 2305 applied to the 2003 cost reports was entirely in keeping with *and required by* the plain language of Ohio

Adm.Code 5101:3-3-01(A)." (Emphasis added.) *Id.* at ¶ 66.

{¶ 23} CHS essentially seeks to rehash the same arguments it made in *CHS-Lake Erie.* Although CHS disagrees with this court's conclusion that the liquidation of liabilities rule applied to the CHS facilities' 2003 cost reports, CHS fails to point to an obvious error in our decision or raise an issue for consideration that was not fully considered by this court when it should have been.

{¶ 24} CHS additionally asserts this court made an obvious error in affirming the common pleas court's ruling on the unpaid days and unpaid claims issue in the days audit. The common pleas court affirmed the department's motion in limine ruling which precluded CHS from offering evidence of unpaid days or unpaid claims for service at the R.C. Chapter 119 hearings. In *CHS-Lake Erie,* we observed that CHS "had no right under R.C. 5111.06 to address the unpaid days and unpaid claims at the R.C. Chapter 119 hearing on the final fiscal audits." *Id.* at ¶ 79. R.C. 5111.06(B)(2)[2] provides for R.C. Chapter 119 hearing rights when the department takes "any action based upon a final fiscal audit." As "an audit reviews payment made to 'determine the amount of overpayment,'" CHS's unpaid days and unpaid claims were never reviewed by the

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[2] The Medicaid reimbursement statutes and rules have been revised since the time of the events at issue in this case. All references to R.C. Chapter 5111 and Ohio Adm.Code Chapter 5101 throughout this decision are to the versions of those statutes and rules in effect during the fiscal years for which the department sought repayment.

department in the audit and could not be addressed at the R.C. Chapter 119 hearings. *Id.* at ¶ 78, quoting Ohio Adm.Code 5101:3-1-27(B)(1).

{¶ 25} CHS contends it should have been permitted to introduce evidence of unpaid days at the R.C. Chapter 119 hearings because the "unpaid days" were "in the same audit period as the days that were paid and adjusted by ODM." (Appellees/Cross-Appellants' App. for Recon. at 20.) However, the fact that the unpaid days occurred in the same audit period as the paid days does not establish that CHS was entitled to address the unpaid days at the R.C. Chapter 119 hearings. The department necessarily never paid CHS for the unpaid days and, thus, never reviewed the unpaid days in auditing the CHS facilities. CHS fails to point to an obvious error in *CHS-Lake Erie*.

{¶ 26} Based on the foregoing, CHS's application for reconsideration is denied.

III. Application for Consideration En Banc Denied

{¶ 27} An en banc proceeding is one in which all full-time judges of a court who have not recused themselves or otherwise been disqualified participate in the hearing and resolution of a case. App.R. 26(A)(2)(a); *McFadden* at ¶ 10. An en banc proceeding seeks to resolve conflicts of law that arise within a district. App.R. 26(A)(2)(a); *McFadden* at ¶ 10, 15-16. These intradistrict conflicts develop when different panels of judges hear the same issue, but reach different results. *McFadden* at ¶ 15. This "create[s] confusion for lawyers and litigants and do[es] not

promote public confidence in the judiciary." *J.J.* at ¶ 18. "Resolution of intradistrict conflicts promotes uniformity and predictability in the law, and a larger appellate panel provides the best possible means of resolution." *State v. Forrest,* 136 Ohio St.3d 134, 2013-Ohio-2409, ¶ 7, citing *McFadden* at ¶ 15-16.

{¶ 28} App.R. 26(A)(2) governs en banc procedures, providing as follows:

> (a) Upon a determination that two or more decisions of the court on which they sit are in conflict, a majority of the en banc court may order that an appeal or other proceeding be considered en banc. * * * Consideration en banc is not favored and will not be ordered unless necessary to secure or maintain uniformity of decisions within the district on an issue that is dispositive in the case in which the application is filed.
>
> (b) * * * An application for en banc consideration must explain how the panel's decision conflicts with a prior panel's decision on a dispositive issue and why consideration by the court en banc is necessary to secure and maintain uniformity of the court's decisions.

{¶ 29} "[C]onflicting decisions are those which conflict on the same legal issue or question of law." *Frash v. Ohio Dept. of Rehab. & Corr.,* 10th Dist. No. 14AP-932, 2016-Ohio-3134, ¶ 3, citing *J.J.* at ¶ 18. Courts of appeals have discretion to determine whether an intradistrict conflict exists. *McFadden* at paragraph two of the syllabus.

{¶ 30} CHS's contention that a conflict exists between *CHS-Lake Erie* and *Meadowbrook Care Ctr.* and *OMG MSTR LSCO, LLC* is premised on CHS's inaccurate portrayal of certain events which took place at the agency hearings. CHS contends that during the R.C. Chapter 119 hearings the department "determined that some of the patient days the agency had previously refused to pay, should have been paid." (Appellees/Cross-Appellants' Mot. to Certify a Conflict, as converted to App. For Consideration En Banc (hereafter, "Appellees/Cross-Appellants' App. for Consideration En Banc") at 3.) Based on CHS's belief that the department decided to pay previously unpaid patient days at the R.C. Chapter 119 hearings, CHS contends it was required to present other evidence of previously unpaid patient days at the hearings.

{¶ 31} However, the department never determined that previously unpaid patient days should be paid at the hearings as CHS contends. The department introduced a number of exhibits detailing its adjustments to the paid patient days at issue in the days audit at the January 22, 2013 hearing. At the April 8, 2013 hearing, "the department introduced four exhibits to replace four of the exhibits previously introduced at the January 22, 2013 hearing." *CHS-Lake Erie* at ¶ 82. Kierstyn Canter, a department audit manager, explained that the difference between the initial exhibits and the revised exhibits was that the department had "deleted an adjustment to create less of an overpayment." (Tr. Vol. VI at 670.) CHS's counsel asked Canter if the revised exhibits demonstrated that CHS "was entitled to additional revenue for the settlement periods reflected in those four exhibits." (Tr.

Vol. VI at 670.) Canter stated the revised exhibits did not reflect any additional revenue going to CHS, but rather reflected "just a reduction in the amount that the provider owes back to [the department]." (Tr. Vol. VI at 670.)

{¶ 32} In *Meadowbrook Care Ctr.,* a nursing facility argued that the department's audit of the facility's patient days did not constitute a final fiscal audit pursuant to R.C. 5111.06(B)(2). The days audit in *Meadowbrook Care Ctr.* consisted of "a comparison and reconciliation with [the department's] records of amounts paid to other providers" such as "hospice or hospital, for the same patient." *Id.* at ¶ 14. The *Meadowbrook Care Ctr.* court concluded the department's "audit procedures in undertaking the limited adjustments proposed in its adjudication order complied with R.C. 5111.06 and 5111.27." *Id.* at ¶ 21.

{¶ 33} CHS asserts that in *"Meadowbrook,* the facility received a hearing; here, CHS did not." (Appellees/Cross-Appellants' App. For Consideration En Banc at 8.) CHS's contention that it did not receive a hearing is premised on its mistaken belief that it was entitled to introduce evidence of unpaid patient days at the R.C. Chapter 119 hearings. In *Meadowbrook Care Ctr.,* the nursing facility did not attempt to introduce evidence of unpaid days at the R.C. Chapter 119 hearing. Rather, the issue in *Meadowbrook Care Ctr.* was whether the department's method of auditing the facility's patient days was sufficient. There is no conflict on an issue of law between *CHS-Lake Erie* and *Meadowbrook Care Ctr.*

{¶ 34} In *OMG MSTR LSCO, LLC,* the department initiated proceedings against certain long-term care facilities to recover alleged Medicaid overpayments. The facilities filed a complaint in the common pleas court seeking a declaratory judgment that the department's attempt to collect the alleged overpayments was time-barred. The common pleas court granted the department's Civ.R.12(B)(6) motion to dismiss the complaint based on the facilities' failure to exhaust their administrative remedies. The face of the facilities' complaint demonstrated they had failed to exhaust their administrative remedies and that the limited exceptions to the doctrine did not apply. As such, the *OMG MSTR LSCO, LLC* court concluded that the "declaratory judgment action must be dismissed due to appellants' failure to exhaust their administrative remedies." *Id.* at ¶ 19.

{¶ 35} CHS asserts that pursuant to *OMG MSTR LSCO, LLC* it has "absolutely no remedy at all" because it did not "receive a hearing on patient days." (Appellees/Cross-Appellants' App. for Consideration En Banc at 14-15.) However, CHS received an R.C. Chapter 119 hearing on the patient days at issue in the department's final fiscal audits, and appealed the department's ruling on the patient days to the common pleas court and this court. *CHS-Lake Erie* did not concern any issue regarding the failure to exhaust administrative remedies doctrine. There is no conflict on an issue of law between *OMG MSTR LSCO, LLC* and *CHS-Lake Erie*. Moreover, CHS's contention that it has no remedy for its unpaid days lacks merit. In *CHS-Lake Erie,* this court explained that CHS has available avenues of relief to address its contentions

regarding the unpaid days, including seeking reconsideration pursuant to Ohio Adm.Code 5101:3-1-57(B) or seeking a writ of mandamus to force the agency to act on its claims for payment. *Id.* at ¶ 80-81.

{¶ 36} Based on the foregoing, CHS's application for consideration en banc is denied.

{¶ 37} CHS's motion to convert its motion to certify a conflict into an application for consideration en banc and motion to exceed page limitation are granted; CHS's motion to certify a conflict is withdrawn. CHS's application for reconsideration and application for consideration en banc are denied.

Motion to convert granted;
motion to exceed page limit granted;
motion to certify a conflict withdrawn;
application for reconsideration denied;
application for consideration en banc denied.

LUPER SCHUSTER and NELSON, JJ., concur.

IN THE COURT OF APPEALS OF OHIO
TENTH APPELLATE DISTRICT

No. 18AP-897
(C.P.C. No. 16CV-9766)

(REGULAR CALENDAR)

CHS-Lake Erie, Inc. et al.,	)
	)
Appellants-Appellees/	)
Cross-Appellants,	)
	)
v.	)
	)
Ohio Department of Medicaid,	)
	)
Appellee-Appellant/	)
Cross-Appellee.	)
	)

JOURNAL ENTRY

For the reasons stated in the memorandum decision of this court rendered herein on October 22, 2020, it is the order of this court that appellants-appellees/cross-appellants' March 10, 2020 motion to convert and motion to exceed page limit are granted; the February 24, 2020 motion to certify a conflict is withdrawn; and the February 24, 2020 applications for reconsideration and en banc consideration are denied.

BEATTY BLUNT, LUPER SCHUSTER & NELSON, JJ.

By /S/ JUDGE
Judge Laurel Beatty Blunt

Tenth District Court of Appeals

Date:	10-26-2020
Case Title:	CHS-LAKE ERIE INC ET AL -VS- OHIO DEPARTMENT MEDICAID
Case Number:	18AP000897
Type:	JOURNAL ENTRY

So Ordered

/s/ Laurel Beatty Blunt

/s/ Judge Laurel Beatty Blunt

APPENDIX E

IN THE COURT OF COMMON PLEAS,
FRANKLIN COUNTY, OHIO
CIVIL DIVISION

CASE NO. 16 CV 9766

JUDGE MARK A. SERROTT

[Filed: November 27, 2018]

CHS-LAKE-ERIE, INC., et al.,	)
	)
Appellants,	)
	)
v.	)
	)
OHIO DEPARTMENT OF MEDICAID,	)
	)
Appellee.	)
	)

DECISION AND ENTRY AFFIRMING, IN PART, AND REVERSING, IN PART, THE ORDER OF APPELLEE OHIO DEPARTMENT OF MEDICAID
AND
NOTICE OF FINAL APPEALABLE ORDER

SERROTT, J.

I. INTRODUCTION

Appellants, who are related Medicaid-provider nursing homes, appeal from an Adjudication Order

issued by the Ohio Department of Medicaid (ODM) following an audit of the nursing facilities cost reports for calendar year 2003 as well as a "days audit" for the same time frame. The Adjudication Order adopted in full the Hearing Officer's Report and Recommendation that Appellants were not entitled to reimbursement for claimed costs of $11,111,557.96 as well as the Hearing Officer's decision that Appellants could not seek recovery for the "unpaid days" totaling $1,154,822.00.

Appellants initiate this appeal pursuant to R.C. 5111.06 and R.C. 119.12. The underlying record reveals the parties have extensively litigated the issues for over a decade and have provided the Court with thorough briefing. Therefore, the parties being well-informed of the lengthy history, facts, and legal issues, the Court will forego a repetition of those matters. The Court has conducted an *exhaustive* review of the record and relevant law, including examining the thousands of pages of exhibits and reading the hearing transcripts in their *entirety*. In doing so, the Court notes that the Hearing Officer, Appellants, and ODM each accurately summarized the testimony and evidence, with the disputes focused on application of the facts to the relevant law.

Based on the Court's thorough review of the record and the relevant law, the Court summarily rejects Appellants' assignments of error alleging that ODM's audit procedures were not in accordance with Ohio law and that it was improperly foreclosed from seeking recovery for the "unpaid days" totaling $1,154,822.00. The Court adopts the Hearing Officer's Findings of Fact and Conclusions of Law as well as ODM's

arguments and reasoning in reaching this conclusion. For the reasons set forth below, the Court also overrules Appellants' argument that the Hearing Officer was so unfairly biased so as to deprive them of a fair and impartial hearing. However, as explained further below, the Court sustains Appellants' argument that ODM improperly applied the "liquidation of liability rule" to their 2003 cost reports. Therefore, ODM's Adjudication Order is affirmed in part, and reversed, in part.

II. STANDARD OF REVIEW

In a R.C. 119.12 appeal, the Court must affirm the order of the Commission if it is supported by substantial, reliable, and probative evidence. *Our Place, Inc. v. Ohio Liquor Control Comm'n*, 63 Ohio St.3d 570 (1992). "The Ohio Supreme Court has defined reliable, probative, and substantial evidence as follows: (1) 'Reliable' evidence is dependable; that is, it can be confidently trusted. In order to be reliable, there must be a reasonable probability that the evidence is true. (2) 'Probative' evidence is evidence that tends to prove the issue in question; it must be relevant in determining the issue. (3) 'Substantial' evidence is evidence with some weight; it must have importance and value." *Keydon Mgmt. Co. v. Liquor Control Comm'n*, 10th Dist. No. 08AP-965, 2009-Ohio-1809, at ¶5, quoting *Our Place*, supra, at 571.

"[D]etermining whether an agency order is supported by reliable, probative and substantial evidence essentially is a question of the absence or presence of the requisite quantum of evidence." *Univ. of Cincinnati v. Conrad*, 63 Ohio St.2d 108, 111 (1980).

"To some extent, this standard of review permits the court of common pleas to substitute its judgment for that of the administrative agency." *Dep't of Youth Servs. v. Mahaffey*, 10th Dist. Nos. 14AP-389 and 14AP-396, 2014-Ohio-4172, ¶13. "The court must, however, 'give due deference to the administrative resolution of evidentiary conflicts.'" Id., quoting *Univ. Of Cincinnati v. Conrad*, 63 Ohio St.2d 108, 111, 407 N.E.2d 1265 (1980). However, "[w]hile the court must give due deference to the administrative tribunal, it need not rubber stamp an erroneous decision." *Decree v. Columbus*, 10th Dist. No. 89AP-247 (Aug. 17, 1989), citing *Conrad*.

III. DECISION

A. The Hearing Officer's Bias and Deprivation of a Fair and Impartial Hearing

Appellants allege the Hearing Officer was incurably biased in favor of ODM due to her previous employment with the Ohio Attorney General's Office representing similar state agencies. Appellants produce decisions authored by the Hearing Officer in other cases and characterize these as proof that she will only hold a non-discriminatory hearing when the State has no pecuniary interest in the outcome of the proceeding. Appellants accuse the Hearing Officer of accepting the state agencies' allegations as "gospel," ignoring any contrary evidence, and predetermining outcomes based upon this alleged inexcusable partisanship.

"There is a presumption of honesty and integrity on the part of an administrative body unless there is a

showing to the contrary, and the party alleging a disqualifying interest bears the burden of demonstrating that interest to a reviewing court." *Meadowbrook Care Ctr. v. Ohio Dept. of Job & Family Servs.*, 10th Dist. Franklin No. 06AP-871 , 2007-Ohio-6534, ¶23, citing *Ohio State Bd. of Pharmacy v. Poppe*, 48 Ohio App.3d 222 (1988). "While due process entitles an individual before an administrative tribunal to receive a fair hearing before an impartial tribunal, a showing of substantial personal bias will be required before a hearing officer may be disqualified or the results of the hearing vacated. In practice this means a personal bias so extreme as to display clear inability to render a fair judgment." Id. at ¶25, citing *Staschak v State Med. Bd. of Ohio,* 10th Dist. No. 03AP-799, 2004-Ohio-4650. Additionally, "the outcome of a judicial proceeding alone may not stand as proof of bias or partiality." Id. at ¶26, citing *Liteky v. United States*, 510 U.S. 540 (1994).

In *Meadowbrook*, the Tenth District Court of Appeals addressed a similar accusation of bias launched against a hearing officer. The appellant relied upon a "statistical breakdown" of the hearing officer's prior decisions to show that he or she had so rarely ruled against any state agency a lack of bias was statistically impossible. The 10th District rejected this argument, reasoning:

> [i]t is impossible for this court to conclude, in the absence of any corroborating evidence and procedural context regarding the proceedings in which the hearing examiner has purportedly found in favor of state agencies, whether those

> determinations were in fact in favor of agencies, whether they were warranted or not by the merits of the matter before the examiner, and ultimately whether the outcome reflected in the resulting hearing examiner's report did anything less than reflect the relative merits of the arguments put forth by the parties in those matters.
>
> In conclusion, because we agree with the hearing examiner's assessment of the law and facts in the matter, and because the fact that counsel for appellant disagrees with this particular hearing examiner in this and a number of other hearing outcomes does not help appellant, we find that appellant has failed to establish a showing of bias that would amount to a deprival of due process in this particular case.

Id. at ¶¶26-27.

Here, Appellants have presented more than just a statistical analysis and do set forth some context regarding the other decisions to support their claims of bias. However, their arguments merely show their disagreements with the Hearing Examiner's rulings and do not ultimately demonstrate that her reports "did anything less than reflect the relative merits of the arguments put forth by the parties in those matters." Additionally, Appellants have made no showing that these decisions were reversed or found to be erroneous.

Moreover, having read the *entire* hearing transcript, the Court can whole-heartedly state that the Hearing Officer was extremely patient with the counsel and the

parties throughout the lengthy proceedings. The Hearing Officer conducted the proceedings in a fair and impartial manner and afforded all parties wide latitude in presenting their case. The Hearing Officer strove to render all rulings based on legal grounds or the facts developed during the hearing and always explained the basis for her decisions. Additionally, while the Hearing Officer decided the issues against Appellants, she certainly did not simply "rubber stamp" ODM's position. Rather, her detailed decision reflects she thoroughly considered all of the arguments and evidence presented by the parties, and she further set forth the legal or factual rationale for her conclusions.

Appellants have failed to demonstrate that the Hearing Officer was biased or in any deprived them of a fair and impartial hearing, and their argument is overruled.

B. The Liquidation of Liabilities Rule

Appellants contracted with Strategic Nursing Systems ("Strategic") for nursmg and administrative support services and were invoiced the sum of $12,082,000 for those services on December 31, 2003. The invoices indicated "Payment Due Upon Receipt of Invoice." Also on December 31, 2003, Appellants executed "Installment Promissory Notes" in favor of Strategic providing that the debt would be paid over time, with payments to commence in 2005 and to be completed by 2008. Appellants characterized the debt as long-term obligations in its cost report.

In auditing Appellants' 2003 cost reports, ODM initially disallowed the consulting services as it

suspected Strategic was a "related entity," and Appellants did not timely provide documents during the audit to show otherwise[1]. However, during the audit review process, Appellants produced documents establishing they did not acquire ownership of Strategic until 2004, and therefore, Strategic was not a related entity at the time their 2003 cost reports were prepared. ODM still disallowed the costs on the grounds that the costs were not timely liquidated pursuant to a "liquidation of liabilities rule" set forth in the code of federal regulations and the federal Medicare Provider Reimbursement Manual. Appellants argue that the liquidation of liabilities rule only applies to short term liabilities and not the long term notes at issue here. Appellants further contend that the substantial and reliable evidence showed that, during the relevant time period, Medicare applied the liquidation of liabilities rule to reasonable cost systems and not the prospective payment system utilized by ODM in 2003.

Ohio adopted a hierarchy of legal authorities that must be used to determine whether a reported cost is allowable. The hierarchy is as follows: 1) the Ohio Revised Code; 2) the Ohio Administrative Code; 3) the Code of Federal Regulations; 4) the Provider Reimbursement Manual; and 5) Generally Accepted Accounting Principles. O.A.C. 5101:3-3-01(A). Thus, if the Ohio Revised Code and Ohio Administrative Code do not have an applicable provision pertaining to an

---

[1] If Strategic had been a related entity, then what should have been reported was Strategic's costs to provide the services, not the amount billed to Appellants.

issue, ODM is allowed to look to guidance from the Code of Federal Regulations and the Provider Reimbursement Manual. ODM did so in applying Medicare's timely liquidation of liability rule set forth in 42 CFR 413.100 and §2305 of the Provider Reimbursement Manual.

42 CFR 413.100 sets forth 8 categories of costs that, "for purposes of payment Medicare does not recognize" unless the liability is timely liquidated. 42 CFR 413.100(c)(1). Those categories are short term liability; vacation pay and all-inclusive paid days off; sick pay; compensation of owners; nonpaid workers; FICA and other payroll taxes; deferred compensation; and self-insurance. 42 CFR 413.100(c)(2)(i) through (viii). Short term liabilities are required to be liquidated within one year after the end of the cost reporting period in which the liability is incurred. 42 CFR 413.100(2)(i)(A).

Additionally, §2305 of the Provider Reimbursement Manual states:

> [a] short term liability must be liquidated within 1 year after the end of the cost reporting period in which the liability is incurred, subject to the exceptions specified in §§2305.1 and 2305.2. Liquidation must be made by check or other negotiable instrument, cash or legal transfer of assets such as stocks, bonds, real property, etc. *Where liquidation is made by check or other negotiable instrument, these forms of payment must be redeemed through an actual transfer of the provider's assets within the time limits specified in this section.* Where the liability (1) is not liquidated within the 1-year time limit, or

> (2) does not qualify under the exceptions specified in §§ 2305.1 and 2305.2, the cost incurred for the related goods and services is not allowable in the cost reporting period when the liability is incurred, but is allowable in the cost reporting period when the liquidation of the liability occurs.

(Emphasis Added).

In disallowing the consulting costs, ODM reasoned that 1) the consulting services were short term liabilities as the invoices indicated that payment was due upon receipt; and 2) that the short term liabilities were not timely liquidated pursuant to the above provisions because an actual transfer of Appellants' assets did not occur within one year as payments on the promissory notes did not commence until 2005. However, as argued by Appellants, the reliable, probative, and substantial evidence in the record as well as relevant legal authorities demonstrate that, in 2003, Medicare applied the liquidation of liabilities rule to reasonable cost systems and not to the prospective payment system utilized by ODM in 2003. ODM is applying the rule simply because it is within the "hierarchy of authorities," while ignoring the competent and credible evidence demonstrating that Medicare would not have applied the rule to the transaction at issue.

Appellant's expert, John P. Fleischer, a certified public accountant who has been involved in *thousands* of Medicaid audits and settlements testified that he has never seen ODM utilize the Medicare liquidation of liabilities rule and further has never experienced ODM

having an issue with a vendor accepting a promissory note with payment terms beyond a year. ODM responds with the adage that "there is a first time for everything." While the Court agrees with this principle, again, the substantial evidence shows that the Medicare system would not have applied the rule to this transaction. This was borne out by the uncontroverted testimony from Appellants' expert, John Hapchuk, who was retained to render an opinion regarding application of the liquidation of liabilities rule.

There can be no dispute that Mr. Hapchuk is highly qualified and has significant expertise to opine on Medicare cost reports and allowable costs. Mr. Hapchuk is a Certified Fraud Examiner and Certified Government Financial Manager with over 40 years of experience in the Medicare industry including performing audits of Medicare cost reports. Mr. Hapchuk opined that, in 2003, Medicare would not have applied the liquidation of liabilities rule to costs that were calculated or reimbursed under a prospective payment system. Rather, the rule was applied to costs reported under reasonable cost or retrospective payment system.

Under a reasonable cost payment system, a Medicare provider reports its actual costs of serving Medicare patients and is reimbursed for those costs that are determined to be reasonable. See *Washington Regional Medicorp v. Burwell*, 72 F. Supp. 3d 159, 161 (D.D.C.2014). Mr. Hapchuk explained that the rule would not have been applied to a cost reported under a prospective payment system. Mr. Hapchuk's expert

opinion is supported by relevant federal authorities. In adopting 42 CFR 413.100 in 1995, the Federal Register explained that the policy would not apply to providers and costs subject to a prospective payment system:

> [g]enerally, under the Medicare program, health care providers not subject to prospective payment are paid for the reasonable costs of the covered items and services they furnish to Medicare beneficiaries. This policy pertains to all services furnished by providers other than inpatient hospital services (section 1886(d) of the Social Security Act (the Act)) and certain inpatient routine services furnished by skilled nursing facilities choosing to be paid on a prospective payment basis (section 1888(d) of the Act.) Additionally, there are other limited services not paid on a reasonable cost basis, to which this policy would not apply.

60 FR 33, 126.

Federal case law has further explained:

> [t]he 1995 Final Rule was ultimately codified at 42 C.F.R. § 413.100, but it was explicitly made inapplicable to inpatient care that was subject to the PPS payment scheme. *See Regents of the Univ. of Cal.,* 155 F. Supp. 3d at 39 * * *. Thus, between 1995 and 2005, hospitals continued to report their wage-related costs in accordance with GAAP with respect to reimbursements for inpatient services, while the expenses that were not subject to the prospective payment system

> were reported only if they were timely liquidated.

Abington Mem. Hosp. v. Burwell, 216 F. Supp. 3d 110, 122 (D.D.C.2016).

During the relevant time frame, "[i]n Ohio, Medicaid-funded nursing homes [were] reimbursed for the reasonable costs of their services on a prospective basis. In other words, [ODM] used the amount of a prior period's allowable costs to calculate the reimbursement rate for a future period. *PNP, Inc. v. Ohio Dept. of Job & Family Servs.*, 10th Dist. No. 04AP-1294, 2006-Ohio-1159, ¶2. The reliable, substantial, and probative evidence demonstrates that the timely liquidation of liabilities rule was not applicable to the costs at issue in 2003[2]. In reaching this conclusion, the Court adopts and incorporates in full the reasoning set forth in Appellants' Reply Brief at pages 17 to 28.

Therein, Appellants accurately discredit any contention that they overinflated their costs for 2003. Appellants were not trying to take advantage of a loophole and did not engage in any gamesmanship from their subsequent purchase of Strategic in 2004. As explained by Appellants, no one has refuted that the

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[2] The *Abington* decision illustrates an instance where the Medicare system applied the liquidation of liabilities rule to certain costs subject to a prospective payment system commencing in 2005. Notably, Medicare did so only after providing notice of the proposed rule so that "hospitals seeking reimbursement for inpatient services should understand *going forward* that * * * timely liquidation principles trumped GAAP." *Abington*, 216 F. Supp.3d 110, 135. (Emphasis Added).

costs and services provided by Strategic were reasonable and necessary and were actual costs incurred by Appellants in operating the nursing home facilities. If the costs were not included, the effect would be to severely underinflate Appellants' reimbursement rate for 2005. The evidence shows that Appellants liquidated those costs through issuing a long term note, which it paid in full. ODM contends Appellants received a "windfall" as it was reimbursed for these costs before it actually paid them with a transfer of actual assets. However, again, there is no "windfall" as the promissory notes have been satisfied. Appellants would have had no reason to know that the debt could not be liquidated through the issuance of a long-term note[3].

Based on the foregoing, the Adjudication Order is REVERSED to the extent the Court finds that ODM erred in applying the timely liquidation of liabilities rule to disallow the consulting costs. The Adjudication Order is AFFIRMED in all other respects. This action is remanded to issue a new order in accordance with this opinion. Costs to ODM.

Pursuant to Civ. R. 58(B), the Clerk of Courts shall notify all parties of the existence of this judgment and its day of entry on the record.

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[3] The Court would also note that both the federal regulation and the provider manual include a process where the provider's fiscal intermediary can grant a three year extension to timely liquidate a liability. Ohio's Medicaid system does not operate through fiscal intermediaries, again underscoring Appellants' argument that these Medicare provisions are not applicable here.

IT IS SO ORDERED.

Electronically Signed By:
JUDGE MARK A. SERROTT

Franklin County Court of Common Pleas

Date:	10-30-2018
Case Title:	CHS-LAKE ERIE INC ET AL -VS- OHIO DEPARTMENT MEDICAID
Case Number:	16CV009766
Type:	DECISION/ENTRY

It Is So Ordered

/s/ Mark A. Serrott

/s/ Judge Mark A. Serrott

Court Disposition

Case Number: 16CV009766

Case Style: CHS-LAKE ERIE INC ET AL -VS- OHIO DEPARTMENT MEDICAID

Case Terminated: 18 - Other Terminations

Final Appealable Order: Yes

APPENDIX F

Ohio
Department of Medicaid
John R. Kasich, Governor
John B. McCarthy, Director

IN THE MATTER OF:	DOCKET NOS.
CHS-Glenwell, Inc. (PN: 2429330)	**09LTC17-19**
CHS-Ohio Valley, Inc. (PN: 2339384)	**09LTC30-33**
CHS-Glenwell, Inc. (PN: 2429321)	**09LTC24-25**
CHS-Miami Valley, Inc. (PN: 2339624 & PN: 2339688)	**09LTC13-16, 34-37**
CHS-Greater Cincinnati, Inc. (PN: 2399033)	**09LTC20-23**
CHS-Lake Erie, Inc. (PN: 2339268)	**09LTC26-29**

ADJUDICATION ORDER

Pursuant to his power and duties under Chapter 119 and 5164 of the Ohio Revised Code, John B. McCarthy,

Director of the Ohio Department of Medicaid ("ODM"), enters this Adjudication Order.

Director McCarthy finds the following: ODM issued proposed adjudication orders for the above-captioned Medicaid providers for the above-captioned docket matters. The providers timely requested hearings under Chapter 119 of the Ohio Revised Code. Initially the above-captioned matters were divided between two hearing examiners. Subsequently, the matters were consolidated under one hearing examiner. The hearing examiner issued the Report and Recommendation on October 31, 2015. After ODM granted two extensions, the providers filed objections to the hearing examiner's Report and Recommendation on December 11, 2015.

After review of the record, including the objections filed by the providers, Director McCarthy affixes his signature and enters this Final Adjudication Order adopting the hearing examiner's findings of fact, conclusions of law and recommendations all of which are attached hereto and incorporated as if fully re-written herein, including all attachments.

Hereby be advised that you may be entitled to appeal this Final Adjudication Order to the Court of Common Pleas of Franklin County pursuant to Section 119.12 and 5164.38 of the Ohio Revised Code. Any adversely affected party desiring to appeal this Order must file a notice of appeal with the Ohio Department of Medicaid, Office of Legal Counsel, Attention: Litigation Coordinator, P.O. Box 182709, Columbus, OH 43218-2709, setting forth the order appealed from and stating that the agency's order is not supported by reliable, probative, and substantial evidence and is not in

accordance with law. The notice or appeal may, but need not, set forth the specific grounds of the party's appeal beyond the statement that the agency's order is not supported by reliable, probative, and substantial evidence and is not in accordance with law. In order to be determined filed with ODM, the notice of appeal must be received by ODM, as evidence by the ODM date and time stamp, no later than fifteen (15) days after the mailing of this Adjudication Order to the affected party. The affected party shall also file the notice of appeal with the court of common pleas no later than fifteen (15) days after the mailing of this Final Adjudication Order to the affected party. In filing a notice of appeal with ODM or the court, the notice that is filed may be the original notice or a copy of the original notice.

OCT - 3 2016
Date of Journalization and
Effective Date of Order

/s/ John B. McCarthy
John B. McCarthy, Director
Ohio Department of Medicaid

I hereby certify this to be a true and exact reproduction of the original Adjudication Order of the Director of the Ohio Department of Medicaid, entered on its journal on October 3rd, 2016.

By:
/s/
Katherine Paull
Litigation Coordinator
Ohio Department of Medicaid

10/3/16
Date of Certification

[SEAL]

OHIO DEPARTMENT OF MEDICAID
50 W. TOWN STREET
COLUMBUS, OHIO

IN THE MATTER OF:

CHS-Glenwell, Inc. 09LTC17-19
CHS-Ohio Valley, Inc. 09LTC30-33
CHS-Glenwell, Inc. 09LTC24-25
CHS-Miami Valley, Inc. 09LTC13-16, 34-37
CHS-Greater Cincinnati, Inc. 09LTC20-23
CHS-Lake Erie, Inc. 09LTC26-29

Mary K. Crawford
Hearing Examiner

Respondents/Providers

October 31, 2015

Report and Recommendation

Appearances: **For the Department of Medicaid**: Mike DeWine, Attorney General, and by William C. Greene and Charity Robl, Assistant Attorneys General, Health and Human Services Section, 26th Floor, 30 East Broad Street, Columbus, Ohio 43215. Phone: (614) 466-8600; Fax: (614) 466-6090.

For the Provider: Geoffrey E. Webster, Webster & Associates Co., LPA, 17 South High Street, Suite 770, Columbus, Ohio 43215: Phone: (614) 461-1156; Fax: (614) 461-7168.

Nature of the Case

These are proceedings taken pursuant to Ohio Revised Code Chapters 119 and 5111.[1] The Ohio Department of Medicaid ("ODM")[2] proposes to implement the findings of cost report audits and/or patient days and patient liability audits conducted of Respondents. Accordingly, the Department issued Proposed Adjudication Orders (PAO), stating its reasons for such proposed action and informing Respondents of their right to a hearing. The parties stipulated that Respondents timely requested a hearing. (Tr., Pt. II, p. 23)

Summary of the Facts

Procedural Matters

Initially, the cases involved in this matter were divided between two hearing examiners. Originally, the above referenced hearing examiner was assigned CHS-

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[1] The provisions of R. C. Chapter 5111 were renumbered under R. C. Title 51 and a few repealed by 130th General Assembly, HB 59.

[2] The Ohio Department of Job and Family Services (ODJFS) issued Proposed Adjudication Orders to Respondents, who timely requested hearings. Since that time, pursuant to Am. Sub. HB 59 of the 130 General Assembly, eff. 7/1/2013, the Ohio legislature has created a new department, Ohio Department of Medicaid (ODM); which has assumed responsibility and authority over the Medicaid cases previously under ODJFS' jurisdiction. Throughout this Report and Recommendation, references made to the Ohio Department of Job and Family Services (ODJFS) or Office of Medical Assistance or Ohio Department of Medicaid (ODM) may be used interchangeably and for ease of reference may be called "the Department."

Glenwell, Inc. Docket Nos. 09LTC17, 09LTC18, 09LTC19, CHS-Hamilton County, Inc. Docket Nos. 09LTC30, 09LTC31, 09LTC32, 09LTC33,[3] and Carington Health Systems Docket Nos. 09LTC24, 09LTC25[4]. Thereafter, the following cases were transferred to the above referenced hearing examiner and the parties agreed to consolidate the cases: CHS-Miami Valley, Inc. Docket Nos. 09LTC13, 09LTC14, 09LTC15, 09LTC16, 09LTC34, 09LTC35, 09LTC36, 09LTC37, CHS-Greater Cincinnati, Inc. Docket Nos. 09LTC20, 09LTC21, 09LTC22, 09LTC23, and CHS-Lake Erie, Inc. Docket Nos. 09LTC26, 09LTC27, 09LTC28, 09LTC29.

Prior to the consolidation, there were three days of hearings in the CHS-Glenwell, Inc. Docket Nos. 09LTC17, 09LTC18, 09LTC19, CHS-Hamilton County, Inc. Docket Nos. 09LTC30, 09LTC31, 09LTC32, 09LTC33, and Carington Health Systems Docket Nos. 09LTC24, 09LTC25 cases to address Respondents' challenge that the Department had not conducted audits. After consolidation, the parties agreed that the determination of whether an audit was conducted

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[3] During the hearing, the parties agreed that the correct name for CHS-Hamilton County, Inc. is CHS-Ohio Valley, Inc. and that the caption of the case be amended to reflect this change. They noted that throughout the proceedings the correct Provider No. was used for the entities. (Tr., Pt. II, pp. 23-4)

[4] During the hearing, the parties agreed that the correct name for CHS-Carington Health Systems is CHS-Glenwell, Inc. and that the caption of the case be amended to reflect this change. They noted that throughout the proceedings the documents the correct Provider No. was used for the entities. (Tr., Pt. II, pp. 23-24)

would apply to all the cases in consolidated case. (Stipulation of the Parties, No. 10)

During Part I of the hearing, sworn testimony was received from Daniel Wilkins, who had recently retired as Section Chief with ODJFS Bureau of Audit; Emily Hess, CPA, Senior Manager with Clifton Gunderson, Public Sector Healthcare Division; Kevin Kent, ODJFS External Audit Supervisor; Kierstyn Canter, ODJFS Audit Manager; Bert Cummins, CPA, designated representative for Respondents; and Christopher Carson, CPA, ODJFS Bureau Chief with Office of Fiscal and Monitoring Services. During Part II of the hearing, sworn testimony was received from Emily (Hess) Wale;[5] John Fleischer, CPA with the firm of Howard, Wershbale & Co.; Kierstyn Canter; John Hapchuk, an independent consultant who had worked with the U.S. Office of the Inspector General as a senior auditor and audit manager over the Medicare program; and Julie Evers, ODJFS Section Chief for Disability and Aging Policy. A court reporter was present for all days of the hearing.

The pages of the transcripts in Part I are numbered consecutively as follows: Vol. I - pp. 1-217; Vol. II - pp. 218-462; Vol. III - pp. 463-685. The pages of the transcripts in Part II are numbered consecutively as follows: Vol. I - pp. 1-7; Vol. II - pp. 8-313; Vol. III - pp. 314-454; Vol. IV - pp. 455-641; Vol. V - pp. 642-649; Vol.

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[5] Ms. Wale's former name was Emily Hess, who had testified during Part I of the hearing. In order to avoid confusion, Ms. Wale will be referred to as Ms. Hess in this Report and Recommendation. (Tr., Pt. II, p. 30)

VI - pp. 650-817; Vol. VII - pp. 818-935; Vol. VIII - pp. 936-1082; Vol. IX - pp. 1083-1116. Throughout the Report and Recommendation, references to the transcript will be indicated as either Part (Pt.) I or II and then the page number.

Background

The Respondents in this matter are: CHS-Glenwell, Inc. [Glen Meadows (provider number 2429330)]; CHS-Ohio Valley, Inc. [Terrace View Gardens (provider number 2339384)]; CHS-Glenwell, Inc. [Wellington Manor (provider number 2429321)]; CHS-Miami Valley, Inc. (Vandalia Park (provider number 2339624)]; CHS-Miami Valley, Inc. [Franklin Ridge (provider number 2339688)]; CHS-Greater Cincinnati, Inc. [East Galbraith Health Care Center (provider number 2399033)]; and CHS-Lake Erie, Inc. [Caington Park (provider number 2339268)]. Respondents operate long-term care facilities, providing room, board and related nursing services to persons eligible for benefits under Ohio's Medicaid program. At the time at issue, ODJFS administered the Medicaid program pursuant to R.C. Chapter 5111 and Title XIX of the Social Security Act.

The Medicaid cost reports at issue in this matter are: 1) the calendar year 2003 Medicaid cost reports filed by Caington Park, Terrace View Gardens, Vandalia Park, and Franklin Ridge; 2) the six-month cost report covering July 1, 2003, to December 31, 2003, filed by East Galbraith Health Care Center; and 3) the three-month cost reports covering December 1, 2003, to February 29, 2004, filed by Glen Meadows and Wellington Manor. The cost reports are collective

referred to as "2003 cost reports." The Department also audited the patient days and patient liability for: 1) Carington Park, Terrace View Gardens, Vandalia Park, Franklin Ridge, East Galbraith Health Care Center for fiscal years 2003, 2004, 2005, and 2006; 2) Glen Meadows for fiscal years 2004, 2005, and 2006; and 3) Wellington Manor for fiscal years 2005 and 2006.

Audit/Agreed Upon Procedures

During the Phase One of the administrative hearings requested by Respondents, the issue addressed was whether an audit was performed of the cost reports for three of the nursing homes.

In order to conduct an audit of a cost report, the person(s) conducting the audit reviews records and documents to ensure that the amounts reported in a provider's annual cost report are reported accurately, are allowable, documented, related to patient care and reasonable. Each cost in a cost report should be verifiable through documentation. (R.C. 5111.27; ODJFS Post Phase One Hearing Memorandum at 1)

ODJFS issued a Request for Proposal (RFP) seeking independent professional auditors to audit the calendar year 2003 Medicaid Nursing Facility Cost Reports. The RFP stated:

> The objective of the contracts resulting from this RFP are to provide ODJFS with the resources necessary to issue the statutory audit reports on cost reports of long term care facilities located in the State of Ohio and certified as providers under the Medicaid program.

> ODJFS is soliciting the services of qualified vendors to perform "Agreed-Upon Procedures" engagements with respect to ODJFS 2524 Medicaid cost reports...for CY2003. These engagements are to be performed in accordance with the provisions contained in this RFP and Attestation Engagements (AT) Section 600 of the AICPA (American Institute of Certified Public Accountants) Codification of Statements for Attestation Engagements.

(Tr., Pt. I, pp. 32, 42; State Exhibit 4, Wellington Manor p. 1672)

A committee with ODJFS' Bureau of Audits reviewed the responses to the RFPs and two firms were selected to conduct the cost report audits. One of these firms was Clifton Gunderson, which has "been performing cost report audits since the Medicaid program began in the mid-1960s ... and [has] served the Ohio Medicaid program since 1999." Emily Hess, who was the Supervisor Manager over the audits at question herein, testified that the audits of CHS at issue herein were conducted in the same manner that it had performed all other cost report audits in Ohio from 2000-2006. For over 12 years, Ms. Hess performed nothing but Medicaid cost report audits for Clifton Gunderson, including 900 - 1,000 in Ohio nursing homes and hospitals. Whenever Clifton Gunderson had an engagement in Ohio, Ms. Hess was the manager assigned. (Tr., P. I, pp. 44-45, 230, 232-34, 319-20; State Exhibit 3, Wellington Manor p. 1559)

As stated in the RFP, the successful vendor was to perform "Agreed-Upon Procedures" engagements for

the CY2003 cost reports. These Agreed-Upon Procedures set forth the scope and method to be utilized in conducting the cost report audits. The Department provided Clifton Gunderson training to review the procedures. Ms. Hess testified that Clifton Gunderson quite frequently performed Agreed-Upon-Procedures with attestation standards for all of their state clients, not just Ohio. She stated that in Agreed-Upon Procedure engagements, the client, i.e. Ohio or other states, would set forth procedures, which told Clifton Gunderson or other vendor what they need to be looking for. (Tr., Pt. I, pp. 148, 236-38)

An example of the reviewer's checklist for Agreed-Upon Procedures is set forth in State Exhibit 1, starting with planning, proceeding step by step all the way to the exit conference and completing the report. The description of the task is listed in one column and the work paper references are filled in as the work is completed. (Tr., Pt. I, pp. 248-49)

Ms. Hess stated that there are different procedures for full-blown financial based audits than for Agreed-Upon Procedures. She stated that the Agreed-Upon Procedures, especially in Ohio, is very in-depth. The purpose of an audit for a financial base is more of a balance sheet for the stockholders. The purpose of an Agreed-Upon Procedures is to validate expenses and revenues. (Tr., Pt. I, pp. 498-99)

Clifton Gunderson assigned a partner, manager, supervisor and three field auditors to the audits at issue herein. In preparing to conduct the audit, Clifton Gunderson contacted CHS on March 1, 2006, over three months prior to the site visit scheduled for the week of

June 12, 2006 at CHS' home office in Hamilton, Ohio, where CHS indicated the relevant documents were housed. In its letter, Clifton Gunderson stated: " To minimize disruptions to you and your staff during the field work phase of the review, please send the information listed on the attached letter to us by April 7, 2006." The attachment listed 32 categories for items to be produced. Furthermore, the list indicated the specific accounts in the cost report to be audited. Ms. Hess stated that CHS only produced documents responsive to one of the requests. (Tr., Pt. I, pp. 301-03; State Exhibit 9, Terrace View, p. 255)

Prior to the site visit, a second request was made for the general ledger accounts, which are comprehensive transaction lists. As stated in the original list, a review of the general ledger was necessary for the auditors to select invoices for the identified cost accounts to be audited. This second request for the general ledger was not honored until after the site visit had commenced. Moreover, during the week-long on-site field work, the auditors were waiting for documents that had been requested from CHS three months previously. (Tr., Pt. I, pp. 304-06)

On the last day of the field work, an exit conference was held and signed off by three Clifton Gunderson staff and David McClellan, the Corporate Controller for CHS at the time. The signed form states: "All of the proposed adjustments *known at this time* were discussed with the Provider and a copy of the proposed adjustments was given to the Provider." (Tr., Pt. I, pp. 258, 307, 365-67; State Exhibit 9, Terrace View pp. 371-72 (italics in original))

At the exit conference, Clifton Gunderson asked CHS to sign the representation letter, which is part of the Agreed-Upon Procedures. CHS' consultant, Cummins, Krasik and Hohl, informed Clifton Gunderson that CHS would not sign it. Ms. Hess explained that Section 600 of the AICPA requires a representation letter, which is usually signed on the last day of field work. This letter is obtained from the entity being audited, in this case, Respondents. The letter should state, among other things, that, to Respondents' knowledge, "they provided all documentation to [Clifton Gunderson], that they were not aware of any fraud from the time that they submitted the cost report to the time" of the audit. Furthermore, they represent that they disclosed "anything else that...to their knowledge would be impactful to the engagement," i.e., anything that would impact or affect the costs reported in the cost reports. The letter used by Clifton Gunderson was a standard form, the template of which was provided by ODJFS. (Tr., Pt. I, pp. 239, 307-11, 506, 608)

Mr. Cummins stated that his firm advised CHS not to sign the form because there was language in the letter that was asking CHS "to agree to the sufficiency of the procedures that they [Clifton Gunderson] performed." When Clifton Gunderson informed the Department of CHS' refusal to sign the letter, Clifton Gunderson was instructed to proceed with the audit as usual. (Tr., Pt. I, pp. 309-10, 548)

At the exit conference Clifton Gunderson also gave CHS a list of still outstanding documents, which was very similar to the list sent in March 2006. This list

included, among other things, invoices, canceled checks and contracts, which would substantiate documentation for reported costs. Ms. Hess stated that providers are required to maintain proper documentation to support costs. Without that documentation, the cost would be removed from the cost report, resulting in an adjustment. The letter stated that if the items were not received by Clifton Gunderson by June 30, 2006, Clifton Gunderson would "make the required adjustments in [its] report to the Ohio Department of Job and Family Services." (Tr., Pt. I, pp. 306, 311, 315-16; State Exhibit 9, Terrace View pp. 377-80)

CHS provided some documentation for expenses prior to the deadline and Clifton Gunderson incorporated that information prior to issuing the proposed cost adjustment letter, which was sent to CHS along with supporting work papers of those adjustments. CHS was given seven days to respond to the report; otherwise, the finalized report would be sent to the Department. CHS did not respond and the draft adjustments were finalized to the Department. The Department received the Audit Input Document, copy of the proposed cost adjustments and papers to support Clifton Gunderson's proposed cost adjustments. (Tr., Pt. I, pp. 105, 317-19)

After the Department received the finalized report from Clifton Gunderson, Kevin Kent[6] of the

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[6] Mr. Kent holds a Masters in Business Administration and a Masters in Accounting and Financial Management. (Tr., Pt. I, pp. 325-26)

Department performed a high level review for accepting the actual audit from Clifton Gunderson. Mr. Kent explained that the review was not detailed. As Mr. Wilkins stated, the Department is not going back to re-perform the work of the contract auditors. Rather, the Department relied upon Clifton Gunderson to perform the detailed review of documentation. The Department is "just ensuring that what has been done is adequately documented in the working papers, and that the adjustments tie back to those working papers that are submitted." He merely reviewed the report to see that the Agreed-Upon Procedures were performed. (Tr., Pt. I, pp. 55, 326-28, 360; State Exhibit 9, Terrace View pp. 1133-41)

During the hearing, Mr. Kent showed the process he went through comparing his checklist of review criteria against the checklist with supporting documents initialed by the auditors as work was completed and, if necessary work papers. He conducted a similar quality review of all seven CHS audits. He stated that Clifton Gunderson passed the audit review he conducted. After Mr. Kent completed his review, then there was a final higher review and a final signoff to accept the audit as done. (Tr., Pt. I, pp. 57, 106, 327-45, 347, 354-61; State Exhibits 1, 9)

The contract auditor's proposed cost adjustments were input into the Perseus system, which is the long-term care's operating system used to calculate payment rates. Proposed cost adjustments were made to the identified accounts where, based upon the audit, the Department believed the costs had been misreported. Mr. Wilkins testified that the procedures for audits,

starting with the RFP, the contractor's work and the Department's process after receiving deliverables from the contract auditor have been the same since 1999. He stated that the Agreed-Upon Procedures have been modified periodically since 1999. He testified that Clifton Gunderson followed the Agreed-Upon Procedures as prescribed in the RFP. (Tr., Pt. I, pp. 59, 107, 118, 125-26, 155)

A final fiscal audit conference or exit conference may be conducted by the Department's Bureau of Audit "to try and resolve potential findings identified by the Department with the providers." This final fiscal audit conference, which is different than the exit conference held between Clifton Gunderson and CHS immediately after the on-site field work was completed in June 2003, is not mandatory. Ms. Canter stated that it is a courtesy provided by the Department to try to resolve proposed findings. After a cost report audit performed by either the Department or a contract independent auditor, the Department has the option to continue trying to work with the provider or to issue a Proposed Adjudication Order under R.C. Chapter 119 whereby the provider may request a hearing. One other option is for the provider to pay the amount identified by the Department as due and owing. (Tr., Pt. I, pp. 411, 413-14, 416, 427)

In this case, Respondents requested final fiscal audit conferences. The Department, however, elected to issue Proposed Adjudication Orders, affording Respondents an opportunity to request a hearing under R.C. Chapter 119. Ms. Canter stated that attempts to meet and to obtain additional documents in order to try

to resolve some of the matters were unsuccessful. One of the factors in the Department's decision to forego the final fiscal audit conferences was the difficulty in obtaining documents from CHS, not only during the audit itself, but also during the exit conference process. (Tr., Pt. I, pp. 191, 416, 427-28, 439)

Days Audits

Days audits were also conducted of 1) Carington Park, Terrace View Gardens, Vandalia Park, Franklin Ridge, East Galbraith Health Care Center for fiscal years 2003, 2004, 2005, and 2006; 2) Glen Meadows for fiscal years 2004, 2005, and 2006; and 3) Wellington Manor for fiscal years 2005 and 2006. A days audit is "a review of the claims a provider has submitted for payment for a given fiscal year to determine that the Department had paid the provider appropriately. Some of the issues that are looked at in these audits include: 1) whether the Department paid for dates of service beyond the date of death of a recipient; 2) whether two institutions paid for the some dates of service for a recipient; 3) whether the Department paid for services when another payer should have paid first; 4) whether patient resources were properly identified and applied. (Tr., Pt. I, pp. 108)

For fiscal year 2005 and prior, unless a provider notified the Department that a patient was not in the facility, the Department paid the provider for a full 30 days for that patient. Thereafter, the provider submitted a 9400 document identifying when a recipient was not in the facility or there was a change of resources or any circumstance that would indicate a provider was overpaid. Starting in fiscal year 2006, the

provider submitted a claim for days of service provided to the Medicaid recipient. (Tr., Pt. I, pp. 110, 116)

Under both the systems -- before and after fiscal year 2005 – the Department looked at all claims paid to the institutional providers for a recipient to see if there were any overlaps in payment. There are no on-site reviews of the providers' records. A report is generated of any overlap. The days audits in the cases at issue herein were performed in the same manner as the audit at issue in *Meadowbrook Care Center v. Ohio Dept. of Job and Family Services* (10th Dist. 2007), 2007-Ohio-6534. (Tr., Pt. I, pp. 110-11, 113, 116-17, 159)

In its audits, ODJFS determined that some of the paid patient days were not covered Medicaid days of service. As stated in *Meadowbrook* at ¶ 14, examples of non-covered days include "days on which patients left [the provider's] facility for treatment elsewhere, or for which hospice costs were reimbursed directly to a hospice provider who furnished such care to a resident in [the provider's] facility."

ODJFS also looked at the amount Respondents collected from individual residents for their patient liability, which is "the individual's financial obligation toward the Medicaid cost of care for the medical institution." Ohio Admin. Code 5101:1-39-22.2(B). "The difference between the individual's patient liability and the monthly Medicaid cost of care is the Medicaid vendor payment amount." *Id*.

After performing the patient day/patient liability audits, ODJFS issued Combined Proposed Adjudication

Orders (CPAO) for each open audit period for each of the Respondents. Each CPAO contained Reports of Examination, detailing the "calculation leading to the amount determined to be owed." State's Exhibits 43-46, 78-81, 105-108, 139-142, 169-172, 199-201, and 227-228. Respondents each timely requested an exit conference. Thereafter, ODJFS re-issued CPAO's for each facility for each open audit period, providing Respondents the opportunity to request a R.C. Chapter 119 hearing. State's Exhibits 47-50, 82-85, 109-112, 143-146, 173-176, 202-204, and 229-230. Each Respondent timely requested a Chapter 119 administrative hearing.

During discovery, CHS produced additional documentation, which was reviewed by ODJFS. As a result of this review, ODJFS made some adjustments and created new CPAOs with Reports of Examination. The revised reports reflecting the revised patient days and patient liability adjustments are set forth as follows:

Facility	**Patient Days/ Patient Liability FY Audit at Issue**	**State's Exhibit No.**	**Adjust-ments to Patient Liability**[7]	**Adjust-ments to No. of Paid Patient Days**
Caring-ton Park	FY 2003	242	$8,892.76 p. 19 (column C)	363.5 p. 8 (column E)
Carington Park	FY 2004	243	$5844.28 p. 20 (column C)	167 p. 8 (column E)
Carington Park	FY 2005	244a	$2,849.76 p. 21 (column C)	337 p. 5 (column E)

[7] The patient-liability adjustment amounts in this chart are not the amounts that CHS owes to ODM. The total amounts the CHS facilities owe to ODM are calculated by multiplying the correct number of patient days by the correct rate and subtracting the correct patient liability.

Carington Park	FY 2006	245b	$10,191.70 p. 19 (column C)	374.5 p. 5 (column E)
Terrace View Gardens	FY 2003	246	$6,461.32 p. 15 (column C)	296.50 p. 5 (column E)
Terrace View Gardens	FY 2004	247	$910.00 p. 10 (column C)	51 p. 6 (column E)
Terrace View Gardens	FY 2005	248	$945.00 p. 14 (column C)	19 p. 5 (column E)
Terrace View Gardens	FY 2006	249a	-$3,706.00 p. 10 (column C)	3.0 p. 5 (column E)
Vandalia Park	FY 2003	250	$8378.65 p. 17 (column C)	592.5 p. 6 (column E)

Vandalia Park	FY 2004	251	$0 p. 17 (column C)	198 p. 6 (column E)
Vandalia Park	FY 2005	252a	$528.42 p. 16 (column C)	161.5 p. 5 (column E)
Vandalia Park	FY 2006	253a	-$2990.20 p. 19 (column C)	441 p. 5 (column E)
Franklin Ridge	FY 2003	254	$1,404.98 p. 17 (column C)	175 p. 6 (column E)
Franklin Ridge	FY 2004	255	$2,385.00 p. 14 (column C)	93 p. 6 (column E)
Franklin Ridge	FY 2005	256a	$1,474.88 p. 15 (column C)	61.5 p. 5 (column E)

Franklin Ridge	FY 2006	257a	-$1.563.00 p. 9 (column C)	7 p. 5 (column E)
East Galbraith	FY 2003	258	$0.00 p. 9 (column C)	3 p. 6 (column E)
East Galbraith	FY 2004	259	$405.00 p. 12 (column C)	54.5 p. 6 (column E)
East Galbraith	FY 2005	260a	$0.00 p. 32 (column C)	45 p. 21 (column E)
East Galbraith	FY 2006	261a	$2827.64 p. 19 (column C)	867 p. 5 (column E)
Welling-ton Manor	FY 2005	262	$0.00 p. 10 (column C)	3.5 p. 5 (column E)

Wellington Manor	FY 2006	263	-$18.00 p. 10 (column C)	2.5 p. 5 (column E)
Glen Meadows	FY 2004	264	$994.62 p. 12 (column C)	11.5 p. 6 (column E)
Glen Meadows	FY 2005	265a	$0.00 p. 12 (column C)	16 p. 6 (column E)
Glen Meadows	FY 2006	266a	-$6,385.00 p. 8 (column C)	9 p. 5 (column E)

(Ohio Department of Medicaid's Post-Hearing brief, pp. 7-8; Tr., Pt. II, pp. 339-54)

Pursuant to Ohio Admin. Code 5101:6-50-09(A)(4), "Any audit report, report of examination, exit conference report, or report of final settlement issued by ODJFS and entered into evidence [in a R.C. Chapter 119 hearing] is to be considered *prime facie* evidence of what it asserts." Therefore, with the admission of the Reports of Examination, the State met its burden of proof and the burden fell to Respondent to refute the figures. Although Respondent's counsel objected to the

adjustments in the Reports of Examination and did not stipulate to the amounts, no evidence was presented to rebut ODJFS' *prime facie* evidence with respect to patient days and patient liability adjustments. *Vill. of Bellville v. Kieffaber*, (2007) 114 Ohio St. 3d 124 (Tr., Pt. II, p. 333)

Cost Reports and Audits

A. Overview

Each of the seven nursing facilities were required, pursuant to R.C. 51111.26(A)(1)(a) and Ohio Admin. Code 5101:3-20, in effect at the time, to file a cost report annually covering the calendar year or portion thereof in which the facility participated in the Medicaid program. These cost reports were to be prepared pursuant to rules and procedures established by ODJFS. *Id*; see Ohio Admin. Code Chapter 5101:3-3.

The cost reports filed by Respondents for calendar year 2003[8] were used by ODJFS to set the per diem rates for FY2005 and FY2006. (See State Exhibits 53, 88, 115, 150, 177, 207, 231) Pursuant to Ohio Admin.

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[8] Three of the facilities–East Galbraith Health Care Center, Glen Meadows, and Wellington Manor–filed partial calendar year 2003 cost reports because they did not operate for the entire year. East Galbraith Health Care Center filed a six-month cost report covering July 1, 2003, to December 31, 2003. Glen Meadows and Wellington Manor each filed 90-day cost reports covering December 2003, January 2004, and February 2004. Ohio Admin. Code 5101:3-3-20(H). However, the 2003 partial-year cost reports, in addition to the full calendar year 2003 cost reports filed by the other four providers, were used to set the per diem rates for FY 2005 and FY 2006. (State's Post-hearing Brief, fn. 6)

Code 5101:3-3-01(A), allowable costs, specifically, those costs that were actually incurred and were reasonable, are determined in accordance with a hierarchy of laws and rules as follows: The Ohio Revised Code, then the Ohio Administrative Code, then the Code of Federal Regulations, then the CMS HIM publications or Provider Reimbursement Manual publications and lastly, the general accepted accounting principles (GAAP). Ohio Admin. Code 5101:3-3-01; Ohio Admin. Code 5101:3-3-20. (Tr., Pt. II, pp. 95-96, 949-50; State Exhibit 275a)

Under this hierarchy, the Ohio Revised Code is applied first. If that source does not specifically address an issue, then the Ohio Administrative Code is applied. If that source does not specifically address an issue, then the Code of Federal Regulation is applied. If that source does not specifically address an issue, the Provider Manual or CMS Publication 15-1[9] is applied. And, finally, if there is complete silence, then general accepted accounting principles are applied. (Tr., Pt. II, pp. 957)

It is noted that the CFR and PRM are regulations and interpretive guidelines for reportable costs for Medicare cost reports. By including them in the hierarchy of sources to use in determining allowable costs for Medicaid nursing facilities, Ohio adopted these regulations to determine allowable costs for Medicaid cost reports in Ohio. 5101:3-3-01(A) There is

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[9] Publication 15-1, HIM-15-1, HIM-15, Provider Reimbursement Manual (PRM) and CMS-15-1 are different names for the same document. (Tr., Pt. II, p. 955)

nothing in the Ohio Administrative Code that states that certain provisions of the CFR or the PRM are not applicable to reporting costs in a cost report. Moreover, there is nothing in the CFR or the PRM that limits the application of any of the rules included therein to only Medicare or only Medicaid. (Tr., Pt. II, pp. 484-85, 958)

After conducting an audit of the 2003 cost reports, ODJFS determined that CHS had improperly reported costs in its cost reports. Many of the cost adjustments that Clifton Gunderson calculated during the audit were based upon insufficient documentation. During the discovery phase of this administrative hearing process, CHS provided ODJFS with additional information and documentation. After reviewing this documentation, adjustments were made to the cost adjustments. In some instances, the additional documents supported the reported costs, thereby enabling ODJFS to delete the adjustment. In other circumstances, the parties agreed that certain costs should not have been included in the cost report and the original cost adjustments remained. As a result of this review and the agreement of the parties, ODJFS and CHS stipulated to the new cost adjustments. These stipulated adjustments are set forth in State Exhibit 267a.[10] (Attached hereto as Attachment A and incorporated herein)

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[10] It is noted that paragraph 4 of the Stipulation of the Parties, there is reference to State Exhibit 267 as the document that summarizes the agreed upon cost adjustments. During the hearing, additional information was provided which resulted in recalculation of some of these stipulated cost adjustments. The parties agreed that the amended stipulated cost adjustment is State Exhibit 267a.

The parties, however, did not agree on all the cost adjustments. The disputed adjustments are set forth in State Exhibit 268. (Attached hereto as Attachment B and incorporated herein) Although the parties agree as to amounts set forth in State Exhibit 268, they disagree as to whether those costs should have been included in the first place. (Stipulations of the Parties, no. 5, attached hereto as Attachment C) These adjustments were made for direct-care consulting costs, found at State Exhibit 268, p. 1, indirect care consulting costs, found at State Exhibit 268, p. 2 and Cincinnati Reds tickets, found at State Exhibit 268, p. 3.

Accordingly, the disagreement between the parties relates to:

1. Inclusion of costs for direct-care consulting (account 6210) and indirect-care consulting (account 7215) in its 2003 cost reports

2. Inclusion of costs for Cincinnati Reds tickets in its 2003 cost reports

The parties have stipulated to the documents supporting these reported costs and also to the amounts in dispute. (State Exhibit 268 and Stipulation of Parties).

B. Cost Reports

Cost reports, which are based on a calendar year, are the mechanism by which nursing home facilities report their operating costs to the State. These cost reports are prepared by the nursing facilities and submitted to the State. Providers use the accrual basis of accounting when reporting costs on a cost report.

Within each cost report are separate cost centers: direct care, indirect care, capital cost, other protected. Each of these cost centers is divided into cost accounts. The Ohio Administrative Code outlines what is included in each cost account and cost center. The State then uses the cost reports in a rate-setting formula to establish a per diem rate, which is the amount that a facility is paid for each person in the facility. The sum of the various cost accounts comprises the total for the respective cost center. The totals of the cost centers are used to determine that provider's rate. There is a different rate for each cost center. (Tr., Pt. II, pp.92-94, 96-97, 283-84, 376, 1012)

Over the years, Ohio has used different reimbursement systems for Medicaid as it relates to nursing homes. Prior to 1991, Ohio used a retrospective cost settlement system. Under this system, the cost report data was used "to establish ceilings, calculated rates, multiplied the rate calculated by the number of Medicaid days, and compared that to the total payments made during the calendar year period." If the State paid the nursing home more than it should have, the nursing home would repay the money. If the Sate did not pay the nursing home as much as the cost, the State would pay additional funds to the provider. (Tr., Pt. II, pp. 746, 1004, 1008)

In 1992, the State started transitioning into a prospective cost based system, which came into place in 1994 and continued for 11 years, through FY 2005. In the prospective cost-based system, a rate was established for each facility, based upon its costs (subject to ceilings). This rate was established prior to

the beginning of the fiscal year for which it became effective and there was no reconciliation as to "what the provider actually spent in that period." (Tr., Pt. II, pp. 1009-10)

Julie Evers with the Department's Office of Ohio Health Plans, explained the prospective cost-based system in a little more detail. Cost data was collected from calendar year cost reports and an 18-month inflation factor to the costs on that cost report was applied to establish a rate for the subsequent fiscal year. The cost reports for 2003 were used in establishing the rates for FY 2005, which started July 1, 2004. Ms. Evers said that under the prospective cost-based reimbursement system, the rate for nursing facilities were based upon actual costs. Each facility had its own unique rate. (Tr., Pt. II, pp. 746, 1011, 1029-30)

In 2005, the Ohio legislature passed laws which changed the reimbursement system from the cost-based prospective reimbursement system to a price-based prospective system. During the transition period, the rates in FY 2006 were the same as those in FY 2005. In FY 2007, the new rates under the price-based prospective system went into effect. (Tr., Pt. II, pp. 1030-31)

Under the price-based prospective system, the State pays "similarly-situated homes the same price subject to case mix adjustments." Rather than looking at the facility's costs, the State looks at "the peer group experience to establish the rate components," while still starting with a calendar year cost report and applying an 18-month inflation factor. (Tr., Pt. II, p. 1034)

In order to claim any expense in a cost report, the facility must have documentation, such as general ledgers, trial balance, invoices, cancelled checks, bank statements, contracts, leases, and loans, to substantiate the expense. If the provider does not supply documentation to substantiate the costs, that cost is eliminated or disallowed due to lack of documentation. An adjustment is made on the Proposed Cost Adjustment Reports form. Each adjustment reduces the amount that was originally reported by the provider on its cost report. (Tr., Pt. II, pp. 94-95, 98-103)

After the cost report audits are conducted,[11] any audit adjustments are entered into the Perseus system, which also contains cost reports and sets the initial rates for nursing homes. After the adjustments are entered, Perseus calculates a new rate. These revised rates are incorporated into combined proposed adjudication reports[12] (CPA report), which are sent to nursing homes notifying them of the amount, if any, owed back to the State. (Tr., Pt. II, pp. 377-78)

Direct Care and Indirect Care Consulting Costs

A. *The Contracts*

Each of the CHS facilities at issue herein contracted with Strategic Nursing Systems ("Strategic") and/or

[11] One of the major purposes of the audit it to substantiate a cost claimed on the cost report. (Tr., Pt. II, pp. 97)

[12] Combined Proposed Adjudication reports are also called final fiscal audit reports. (Tr., Pt. II, pp. 378)

Providers Choice Administrative Services ("Providers" or "Providers Choice") for consulting services. Most of these contracts consisted of two parts: Annual Services and Enhanced Services. The Enhanced Services portion of the contract was to pay Strategic and/or Providers "additional fees as specified in Attachment A" of the contract. (See, eg., State Exhibit 57, p. 5)

Under the "Annual Services" part of the contracts, the facilities were invoiced monthly. Each of the monthly invoices stated that payment was due upon receipt of invoice. The facilities paid these invoices by check.

Under the "Enhanced Services" part of the contracts (Attachment A to the contract), rather than sending monthly invoices, Strategic and Provider invoiced the facilities on December 31, 2003 for the entire amount for services provided from January 1, 2003 through December 31, 2003. These invoices stated that payment was due upon receipt of invoice.

During the audit, the auditor disallowed these costs because there was inadequate documentation and there was a related party issue. For example, Ms. Hess testified that during the audit, the auditors asked for accounts with respect to Strategic and they looked for specific transactions in account 6210. They did not get invoices, canceled checks, promissory notes, payments of checks on the promissory notes (Tr., Pt. II, pp. 206-08)

Since CHS presented documentation during discovery, ODM is no longer proceeding on the issue of inadequate documentation or related party issue. The

additional documentation, however, revealed an issue with liquidation of liabilities. This issue was not identified originally because CHS failed to provide the documentation (Tr., Pt. II, p. 16)

With respect to cost account 6210, the parties stipulated:

A. CHS – Lake Erie, Inc. d.b.a. Carington Park, provider number 2339268, entered into an agreement with Strategic Nursing Systems, Inc., at State's Exhibit 57. The costs associated with this consulting agreement were reported in account 6210. Strategic Nursing Systems, Inc. invoiced Carington Park monthly for the consulting fees and Carington Park paid each invoice by check as shown in State's Exhibit 58. The consulting agreement (State's Exhibit 57) contained an Attachment A for Enhanced Services, with an additional consulting fee that was due on December 31, 2003, that was invoiced by Strategic Nursing Services as shown by State's Exhibit 59. Carington Park issued an installment promissory note for the December 31, 2003 for the Enhanced Services invoice, State's Exhibit 60. The payments of the installment promissory note were per the note's terms and were by checks at State's Exhibit 61.

B. CHS – Hamilton County, Inc. d.b.a. Terrace View Gardens, provider number 2339384, entered into an agreement with Strategic Nursing Systems, Inc. at State's Exhibit 92. The costs associated with this consulting agreement were reported in account 6210. Strategic Nursing Systems, Inc. invoiced Terrace View Gardens monthly for the consulting

fees and Terrace View Gardens paid each invoice by check as shown in State's Exhibit 93. The consulting agreement (State's Exhibit 92) contained an Attachment A for Enhanced Services, with an additional consulting fee that was due on December 31, 2003, that was invoiced by Strategic Nursing Services as shown by State's Exhibit 94. Terrace View Gardens issued an installment promissory note for the December 31, 2003 Enhanced Services invoice, State's Exhibit 95. The payments of the installment promissory note were per the note's terms and were by checks at State's Exhibit 96.

C. CHS – Miami Valley, Inc. d.b.a. Franklin Ridge, provider number 2339688, entered into an agreement with Strategic Nursing Systems, Inc. at State's Exhibit 119. The costs associated with this consulting agreement were reported in account 6210. Strategic Nursing Systems, Inc. invoiced Franklin Ridge monthly for the consulting fees and Franklin Ridge paid each invoice by check as shown in State's Exhibit 120. The consulting agreement (State's Exhibit 119) contained an Attachment A for Enhanced Services, with an additional consulting fee that was due on December 31, 2003, that was invoiced by Strategic Nursing Services as shown by State's Exhibit 121. Franklin Ridge issued an installment promissory note for the December 31, 2003 Enhanced Services invoice, State's Exhibit 122. The payments of the installment promissory note were per the note's terms and were by checks at State's Exhibit 123.

D. CHS – Miami Valley, Inc. d.b.a. Vandalia Park, provider number 2339624, entered into an agreement with Strategic Nursing Systems, Inc. at State's Exhibit 154. The costs associated with this consulting agreement were reported in account 6210. Strategic Nursing Systems, Inc. invoiced Vandalia Park monthly for the consulting fees and Vandalia Park paid each invoice by check as shown in State's Exhibit 155.

E. CHS-Greater Cincinnati, Inc., d.b.a. East Galbraith Health Care Center, provider number 2399033, entered into an agreement with Strategic Nursing Systems, Inc. at State's Exhibit 181. The costs associated with this consulting agreement were reported in account 6210. Strategic Nursing Systems, Inc. invoiced East Galbraith monthly for the consulting fees and East Galbraith paid each invoice by check as shown in State's Exhibit 182. The consulting agreement (State's Exhibit 181) contained an Attachment A for Enhanced Services, with an additional consulting fee that was due on December 31, 2003, that was invoiced by Strategic Nursing Services as shown by State's Exhibit 183. East Galbraith issued an installment promissory note for the December 31, 2003 Attachment A Enhanced Services invoice, State's Exhibit 184. The payments of the installment promissory note were per the note's terms and were by checks at State's Exhibit 185. The consulting agreement (State's Exhibit 181) also contained an Attachment B for Enhanced Services, with an additional consulting fee that was due on December 31, 2003, that was invoiced by Strategic Nursing Services as shown by

> State's Exhibit 186. East Galbraith issued an installment promissory note for the December 31, 2003, Attachment B Enhanced Services invoice, State's Exhibit 187. The payments of the installment promissory note were per the note's terms and were by checks at State's Exhibit 188.

(Stipulation of the Parties, ¶ 6)

With respect to cost account 7215, the parties stipulated:

> A. CHS – Lake Erie, Inc. d.b.a. Carington Park, provider number 2339268, entered into an agreement with Providers Choice Administrative Services, Inc., at State's Exhibit 63. The costs associated with this consulting agreement were reported in account 7215. Providers Choice Administrative Services, Inc. invoiced Carington Park monthly for the consulting fees and Carington Park paid each invoice by check as shown in State's Exhibit 64. The consulting agreement (State's Exhibit 63) contained an Attachment A for Enhanced Services, with an additional consulting fee that was due on December 31, 2003. Carington Park issued an installment promissory note for the December 31, 2003 Enhanced Services fee, State's Exhibit 65. The payments of the installment promissory note were per the note's terms and were by checks at State's Exhibit 66.
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> B. CHS – Hamilton County, Inc. d.b.a. Terrace View Gardens, provider number 2339384, entered into an agreement with Providers Choice Administrative Services, Inc., at State's Exhibit 98. The costs

associated with this consulting agreement were reported in account 7215. Providers Choice Administrative Services, Inc. invoiced Terrace View Gardens monthly for the consulting fees and Terrace View Gardens paid each invoice by check as shown in State's Exhibit 99. The consulting agreement (State's Exhibit 98) contained an Attachment A for Enhanced Services, with an additional consulting fee that was due on December 31, 2003. Terrace View Gardens issued an installment promissory note for the December 31, 2003, Enhanced Services fee, at State's Exhibit 100. The payments of the installment promissory note were per the note's terms and were by checks at State's Exhibit 101.

C. CHS – Miami Valley, Inc. d.b.a. Franklin Ridge, provider number 2339688, entered into an agreement with Providers Choice Administrative Services, Inc., at State's Exhibit 125. The costs associated with this consulting agreement were reported in account 7215. Providers Choice Administrative Services, Inc. invoiced Franklin Ridge monthly for the consulting fees and Franklin Ridge paid each invoice by check as shown in State's Exhibit 126. The consulting agreement (State's Exhibit 125) contained an Attachment A for Enhanced Services, with an additional consulting fee that was due on December 31, 2003. Franklin Ridge issued an installment promissory note for the December 31, 2003, Enhanced Services fee, at State's Exhibit 127. The payments of the installment promissory note were per the note's terms and were by checks at State's Exhibit 128.

D. CHS – Miami Valley, Inc. d.b.a. Vandalia Park, provider number 2339624, entered into an agreement with Providers Choice Administrative Services, Inc., at State's Exhibit 157. The costs associated with this consulting agreement were reported in account 7215. Providers Choice Administrative Services, Inc. invoiced Vandalia Park monthly for the consulting fees and Vandalia Park paid each invoice by check as shown in State's Exhibit 158. The consulting agreement (State's Exhibit 157) contained an Attachment A for Enhanced Services, with an additional consulting fee that was due on December 31, 2003. Vandalia Park issued an installment promissory note for the December 31, 2003, Enhanced Services fee, at State's Exhibit 159. The payments of the installment promissory note were per the note's terms and were by checks at State's Exhibit 160.

E. CHS-Greater Cincinnati, Inc., d.b.a. East Galbraith Health Care Center, provider number 2399033, entered into an agreement with Providers Choice Administrative Services, Inc., at State's Exhibit 190. The costs associated with this consulting agreement were reported in account 7215. Providers Choice Administrative Services, Inc. invoiced East Galbraith monthly for the consulting fees and East Galbraith paid each invoice by check as shown in State's Exhibit 191. The consulting agreement (State's Exhibit 190) contained an Attachment A for Enhanced Services, with an additional consulting fee that was due on December 31, 2003. East Galbraith issued an installment promissory note for the December 31,

> 2003, Enhanced Services fee, at State's Exhibit 192. The payments of the installment promissory note were per the note's terms and were by checks at State's Exhibit 193.

(Stipulation of the Parties, ¶ 7)

Some of the monthly invoices for services under the annual contracts were paid more than one year after the end of the relevant cost-reporting period. The following chart shows that the invoices were issued in November and/or December 2003. The checks to pay these invoices, however, were not paid to Strategic until March 2005 and/or April 2005.

Facility	Invoice Month	Date Checks were Issued	End of Cost-Reporting Period	State's Exhibit Number	CHS's Exhibit Number
Terrance View Gardens	December 2003	March 2005	12/31/2003	State's Exhibit 93, pp. 23-24	CHS Exhibit RRR, TVG000734-000735
Franklin Ridge	December 2003	March 2005	12/31/2003	State's Exhibit 120 pp. 23-24	CHS Exhibit FFFF, FR001194-001195
Vandalia Park	December 2003	March 2005	12/31/2003	State's Exhibit 155 pp. 23-24	CHS Exhibit NNN, CP000727-00728[13]

[13] When CHS produced documents during discovery, it inadvertently labeled Vandalia Park documents with the Bates-Number prefix CP and Carington Park documents with the Bates-Number prefix VP.

Caring-ton Park	Nove-mber 2003 and Dece-mber 2003	March 2005 and April 2005	12/31/ 2003	State's Exhibit 58, pp. 21-25	CHS Exhibit ZZZ, VP000 863-000866
Glen Mead-ows	Dece-mber 2003	March 2005	2/29/ 2004	State's Exhibit 208 pp. 3-4	CHS Exhibit WW, GM009 27-009 28
Wellin-gton Manor	Dece-mber 2003	March 2005	2/29/ 2004	State's Exhibit 234 pp. 4-5	CHS Exhibit HHH, WELL 00065 7-000 658

(State Post-hearing Brief at 14)

Based upon the fact that they were not paid within one year after the end of the cost reporting period, the Department disallowed these costs in the FY2003 cost reports. These amounts are included in the Stipulated Amount columns on State Exhibit 268, pp.1-2 (attached hereto as Attachment B)

In addition to the facilities set forth in the above chart, for disallowance of seven payments on the "Annual Services" monthly invoices, one facility, East

Galbraith, paid all of the monthly invoices for Annual Services for Providers Choice starting in January 2005. These payments were also disallowed in the FY2003 cost report because the payments were not made within one year after the end of the cost reporting period. These amounts are also included in the Stipulated Amount columns on State Exhibit 268, pp.1-2 (attached hereto as Attachment B) (Stipulation of the Parties; State Exhibit 181, pp. 5, 11; State Exhibits 190, 191)

Some of the facilities reported costs in their cost report for the "Enhanced Services." On December 31, 2003, Strategic and/or Providers Choice issued invoices for the total amount of the "Enhanced Services" contracts. The invoice stated "Payment Due Upon Receipt of Invoice." That same day, December 31, 2003, the facilities issued promissory notes in the exact amount of the invoices. Payment on these promissory notes were not to commence until mid-2005. Therefore, none of the facilities' assets were transferred until 2005, over one year from the end of the 2003 cost report period. In July 2005, the facilities began issuing monthly checks to pay the promissory notes.

B. Liquidation of Liabilities

One of the cost accounts in dispute is 6210, which is consulting and management costs related to direct care. For purposes of illustration, during the hearing, ODM used the example of one of the Carington Park facilities, whose cost report was State Exhibit 53. Carington Park reported $2,398,356 in this cost account. Ms. Hess testified that during the audit they sampled "from to vouch expenses, and [they] selected a variety of different journal entries and transactions to

test these amounts." Although Carington supplied the auditors with some invoices and a consulting agreement, Ms. Hess stated that they received very little documentation, even after requesting documentation on this transaction. As a result, an adjustment was made to this account for lack of documentation and related party matters[14]. Ms. Hess testified that the lack of documentation included lack of information regarding the related party issue. (Tr., Pt. II, pp. 97, 104-08, 207; State Exhibit 54)

The consulting agreement between Carington Park and Strategic Nursing Systems provided for Compensation of Consultant: "For the full and efficient performance of its duties and responsibilities hereunder, Consultant shall be paid annually $1,550.00 per licensed bed (the "Consulting fee"), payable in equal installments on or before the 20th day of each month." Ms. Hess stated that Carington provided few, if any, copies of these invoices. (Tr., Pt. II, pp. 108-09; State Exhibit 57, p. 5)

Through discovery in this matter, invoices and checks were received and are set forth in State Exhibit 58. The invoices were dated January 31, 2003, February 29, 2003, March 31, 2003, April 30, 2003, May 31, 2003, June 30, 2003, July 31, 2003, August 31,

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[14] The related party issues were based upon the fact that the 2004 tax returns of the owners of Carington also listed ownership of Strategic Consulting, which was one of the entities that Carington entered into contract with for consulting services in cost account 6210. This issue was later dropped by the Department after receiving documentation during the discovery phase of this case. (Tr., Pt. II, pp. 106-07)

2003, September 30, 2003, October 31, 2003, November 30, 2003, and December 31, 2003. The checks, in the amount of $26,738, were dated September 22, 2003, October 24, 2003, November 24, 2003, December 16, 2003, January 22, 2004, February 24, 2004, March 18, 2004, May 20, 2004, June 19, 2004, July 23, 2004, March 28, 2005 and April 26, 2005. (State Exhibit 58)

Ms. Hess testified that all of these transactions, except the two checks issued in 2005, would have been allowable in the cost report. She stated that funds must be expended within one year of the end of the cost reporting period. Therefore, the checks issued on March 28, 2005 and April 26, 2005 would be disallowed. (Tr., Pt. II, pp. 110-11, 116-17)

There was also an Attachment to this contract for Enhanced Services for the period of January 1, 2003 to December 31, 2003. Under this contract, Strategic Nursing Systems charged Carington Park $10,024 per licensed bed. Since there were 207 beds, the amount of the contract for enhanced services was $2,075,000. The contract specifically stated that the "Invoicing will be submitted on December 31, 2003." (State Exhibit 57)

Therefore, on December 31, 2003, Strategic Nursing Systems submitted an invoice for service provided for the 2013 calendar year in the amount of $2,075,000. The invoice stated "PAYMENT DUE UPON RECEIPT OF INVOICE" Ms. Hess stated that this debt was a short term liability. She said that in order to be an allowable expense, Carington Park would have to pay Strategic for the goods and services within a year of the end of the cost reporting period, i.e. December 31, 2004. The auditors did not receive a copy of this invoice

during the audit. (Tr., Pt. II, pp. 118-20; State Exhibit 59, p. 4)

On December 31, 2003, Carington Park executed an Installment Promissory Note with Strategic in the amount of "$2,075,000, with interest from July 1, 2005 on the unpaid principal at the rate of 5.00% per annum." The promissory note further stated: "The unpaid principal and accrued interest shall be payable in monthly installments of $62,189.61, beginning on August 01, 2005, and continuing until July 01, 2008, (the "Due Date"), at which time the remaining unpaid principal and interest shall be due in full." A copy of this promissory note was not produced during the audit. (State Exhibit 60)

The promissory note itself states that payments are to commence August 2005, which is more than 12 months after the close of the 2003 cost reporting period. State Exhibit 61 contains copies of monthly checks in the amount of $62,189.61 for payments on the promissory note. The first check on payment of the loan is dated July 26, 2005. It is noted that the promissory note was to be paid in full by July 1, 2008, but checks in the amount of $62,189.61 continued to be issued in August, September, October and December 2008. None of these checks in State Exhibit 61 were produced during the audit. (Tr., Pt. II, p. 120)

Ms. Hess testified that if they had been produced, the cost would have been disallowed based upon 42CFR 413.100 and Provider Reimbursement Manual section 2305. Ms. Hess further explained that the checks which were written in 2005 would be allowed on the 2005 cost report and those written in 2006 would be allowed in

the 2006 cost report and similarly for 2007 and 2008.[15] (Tr., Pt. II, pp. 121, 128-34)

Ms. Hess was asked if it would have made a difference if Carington had received a loan from a bank for $2,075,000 and then given that money to Strategic. She stated that since the vendor, Strategic, actually received funds to pay for the goods and services, that cost would have been allowed in the 2003 cost report. By providing Strategic a promissory note in lieu of money, however, Strategic did not receive any funds or payment for the goods and service until actual payments commenced in 2005. Ms. Hess stated that the difference is the actual expenditure of funds. (Tr., Pt. II, pp. 135-36)

Ms. Hess stated that by placing the costs for Enhanced Services in cost account 6210, Carington Park classified these costs as short term. Long term liabilities are reported on the balance sheets and interest associated with long-term liability is usually in the capital component. Ms. Hess stated that the current portion of a long-term liability is "technically considered a short term liability as well and it's due within 12 months of that date and time." The long term portion is greater than 12 months. (Tr., Pt. II, pp. 151-52)

The costs in cost account 7215 involve contracts with Provider's Choice Administrative Services. For purposes of illustration, during the hearing, the Department used the example of one of the Carington

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[15] This is supposing that Ohio had the same reimbursement system. The system, however, was changed in FY2006.

Park facilities. In the 2003 cost report, Carington Park reported $694,177. During the audit, the auditors only received a few invoices. The auditors disallowed $625,000 based upon insufficient documentation and related parties transactions. (Tr., Pt. II, pp. 137; State Exhibit 54)

Carington Park entered into an agreement for indirect care consultant services with Providers Choice. Carington Park agreed to pay Provider's Choice $550 per licensed bed, payable 30 days from the date of the invoice. Since there were 207 licensed beds, the monthly charge was $9,488. State Exhibit 64 includes the invoices, starting on January 31, 2003 through December 31, 2003, with the corresponding checks to pay the invoices. The auditors did not receive any of these documents during the audit. (Tr., Pt. II, pp. 139-41; State Exhibit 63)

As with Strategic, Carington Park entered into an Additional Services ("Enhanced Services") agreement in which Providers Choice charged $2,730 per licensed bed. As with Strategic, the contract specifically stated that invoicing will be submitted on December 31, 2003. (State Exhibit 63, pp. 6-7)

On December 31, 2003, Carington Park executed an Installment Promissory Note with Providers Choice in the amount of " $565,000, with interest from February 1, 2005 on the unpaid principal at the rate of 5.00% per annum." The promissory note further stated: "The unpaid principal and accrued interest shall be payable in monthly installments of $24,787.34, beginning on February 1, 2005, and continuing until January 1, 2007, (the "Due Date"), at which time the remaining

unpaid principal and interest shall be due in full." A copy of this promissory note was not produced during the audit. (Tr., Pt. II, pp. 142-44; State Exhibit 65)

The promissory note itself states that payments are to commence February 2005, which is more than 12 months after the close of the 2003 cost reporting period. State Exhibit 66 contains copies of monthly checks in the amount of $24,787.34 for payments on the promissory note. The first check on payment of the loan is dated March 29, 2005 and continued through December 18, 2006. None of these checks in State Exhibit 66 were produced during the audit. (Tr., Pt. II, p. 145)

Although ODM counsel just went through the promissory note payment and time of payments analysis for Carington Park, Ms. Hess testified that there was a same scenario with the other facilities. She stated that the auditors received approximately the same amount of documentation for the other facilities as for Carington Park. Therefore, at the time of the audit, the costs were disallowed for lack of documentation and what the auditors thought was a related party issue. After reviewing the documentation received during discovery in this matter, however, the liquidation of liabilities issues became the basis for disallowance. Ms. Hess testified that if the contracts, invoices, promissory notes and checks had been produced during the audit, the cost would have been disallowed based upon 42CFR 413.100 and Provider Reimbursement Manual section 2305. Moreover, she testified that the same analysis would apply to all the

other Carington Health Systems facilities at issue in this case. (Tr., Pt. II, pp. 144-45)

In August 2004, prior to making any payments on these promissory notes, Carington Health Systems purchased Strategic for $4.6 million. Therefore, CHS "owed the money to themselves. Strategic has a receivable of $12 million. And when it was acquired, it became part of the combination, and they eliminated." (Tr., Pt. II, p. 894)

Respondents presented the testimony of John Fleischer and John Hapchuk to address the issue of liquidation of liabilities.

John Fleischer has been a certified public accountant since 1982. His firm, Howard, Wershbale & Co., does a lot of work for nursing homes. Providers Choice, which is currently one of the clients of Mr. Fleischer's firm,[16] is one of the companies that received promissory notes that are at issue in this case. (Tr., Pt. II, pp. 226-27)

Mr. Fleischer also does consulting to the long-term care industry and has been involved with a "couple thousand" Medicaid audits and audit settlements. He acknowledged that he does not perform the cost reports for nursing home facilities, but reviews them for other members of his firm. He said, however, he did prepare them about 20 years ago. He has also served as

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[16] Mr. Cummins, the designated representative for Respondents in this matter, and a CPA, merged with Mr. Fleisher's firm in January 2011. (Tr., Pt. II, p. 225)

chairman of the Ohio Health Care Association's[17] payment committee. (Tr., Pt. II, pp. 218-19, 228)

Prior to presenting his testimony in this matter, Mr. Fleischer did not review any of the exhibits in this case. He had not seen any of the contracts between Carington Park and Strategic. He did, however, look at some of Mr. Cummins' work papers. (Tr., Pt. II, pp. 228-30)

Mr. Fleischer has seen many instances in which providers report costs which have been paid by a negotiable instrument, including in the 1980's when providers got "lines of credit that they couldn't pay and then would refinance those into long-term debt." He explained that on the cost report there are two lines of interest – the working capital interest and the long-term capital asset interest. Generally, the working capital interest resulted from facilities being unable to pay their vendors and refinance or convert into long-term debt or note with a bank or sometimes the vendors themselves. Mr. Fleischer stated that the entire expense would be recorded on the cost report since it was incurred in that year and it was liquidated by a long-term note. He admitted that this was not a common practice and, in his experience has occurred less than six times over the course of 20 years. He further clarified that if he were looking only at such transactions with vendors, it would be even more limited. (Tr., Pt. II, pp. 221-24)

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[17] Ohio Health Care Association is the trade association which represents nursing homes and assisted living facilities. (Tr., Pt. II, pp. 227-228)

When asked whether there was a specific rule in the CFR which addresses costs not paid in the year they were incurred, Mr. Fleischer stated there was a rule regarding liquidation of liabilities. When asked if he had an understanding of the liquidation of liabilities rule, he responded that he had "looked at it a little bit." He said he has never seen the rule applied in the manner the Department has applied it in this case. Moreover, he was uncertain whether the rule was applicable in Medicaid. (Tr., Pt. II, pp. 221, 232)

He stated that cost reporting is to be on the accrual basis of accounting and, in accordance with generally accepted accounting principles, when costs are reported in the year that they incur. He acknowledges that 42 CFR 413.100 is a rule dealing with "special treatment of certain accrued costs." Mr. Fleischer acknowledged that under this rule, in the case of accrued costs for which a provider has not actually expended funds during the current cost reporting period, such costs are not recognized unless the related liabilities are liquidated timely. He defined liquidation of liability as a payment of cash, transfer of other assets or a presentation of a long-term debt instrument, such as a promissory note. (Tr., Pt. II, pp. 232-33, 237-39)

Mr. Fleischer also acknowledged that there is a liquidation of liabilities rule in the Provider Reimbursement Manual (PRM). Although the PRM rule is similar to the 42 CFR 413.100, the PRM is more explicit, requiring that liquidation "must be made by check or other negotiable instrument, cash or legal transfer of assets such as stocks, bond, real property, etc. Where liquidation is made by check or other

negotiable instrument, these forms of payment must be redeemed through an actual transfer of the provider's assets within the time limits specified in this section." (PRM 2305)

Mr. Fleischer stated that if a facility takes "an ordinary expense and makes it part of a long-term liability, . . . the liability has been liquidated within one year." He admitted, however, that if an invoice is due immediately, it is a short-term liability. The invoices for Strategic and Providers Choice state "Payment due upon receipt of invoice." (Tr., Pt. II, pp. 241-42, 258, 278)

Mr. Fleischer was given a scenario of Carington Park, getting a promissory note from the bank, taking the cash it got from the bank and giving the cash to Strategic. Mr. Fleischer agreed that in this scenario there was a transfer of funds. In the herein matter, however, Strategic did not get any money in their account as a result of the promissory note. Strategic took the note in lieu of cash. The first time Strategic got any money under this contract was July 2005. (Tr., Pt. II, pp. 295, 302-06)

Mr. Fleischer acknowledged that a promissory note does not make any actual transfer of provider assets. A check, however, is a transfer of funds. The first check issued to pay the promissory note was dated July 26, 2005. He agreed that the promissory note for $2,075,000 did not transfer any assets from Carington to Strategic. Strategic took the note in lieu of cash. The promissory note did, however, liquidate the liability for purposes of GAAP and reporting financial statements. A cost report, however, is not a report of the financial

status of a provider entity. (Tr., Pt. II, pp. 259-61, 281; State Exhibit 61, p. 1)

PRM 2305 states that where liability is not liquidated with the 1-year time limit, "the cost incurred for the related goods and services is not allowable in the cost reporting period when the liability is incurred, but is allowable in the cost reporting period when the liquidation of the liability occurs." (emphasis added) Mr. Fleischer stated that under the rule, the facility would get its costs back in a later year. Therefore, under this rule, Carington Park would report the payments made on the promissory notes during the year that the payments were made. So for example, the first payment on the promissory note to Strategic which was made on July 26, 2005, in the amount of $62,189.61, would have been reported on the 2005 cost report. (Tr., Pt. II, pp. 248-49)

However, there was a change in the reimbursement system in 2004, and 2005 cost reports were not used to establish rates. Mr. Fleischer said "2003 was a year upon which rates were going to be established and we did not know that 2004 was not going to be used." Therefore, looking in hindsight, Mr. Fleischer stated that this provision of PRM should not apply because there would be "no way to get that reimbursement back at a later time." (Tr., Pt. II, pp. 245, 300-01)

He admitted that had the reimbursement system not changed, the cost reports for 2004 would set the rate for FY2006, and 2005 cost report for FY2007, etc. Therefore, the problem is that there was a change in the law on how the rate was set. "They changed the reimbursement system legislatively where they weren't

going to use the cost report anymore and that's part of why these rules don't make sense. These rules are designed for an ongoing reimbursement system." He admitted that the rules made sense prior to the change in legislation. (Tr., Pt. II, pp. 250-51)

Respondents also presented the testimony of John Hapchuk, who worked for the U. S. Office of the Inspector General (OIG) in the Office of Audit Services for 40 years. He held various positions of increasing responsibility, serving as a senior auditor and audit manager over the Medicare program. He also served as a Medicaid Audit Manager. Since his retirement in 2010, he has served as an independent consultant. He stated that during his career with the OIG, he answered questions about "the application of Medicare rules and the reimbursement manual." He admitted that he "can speak more from Medicare than Medicaid." (Tr., Pt. II, pp. 461-76, 488-89, 552; Respondent Exhibit NNNN)

Mr. Hapchuk was hired by Respondent to Look at the liquidation of liabilities rule and give his opinion as to its applicability to the consulting costs for Strategic and Providers. He stated that in his years of auditing, he has applied 42CFR413 .100 and PRM 2305 "to cost report audits where the costs are used as a basis to reimburse the provider." He further stated that he does not recall making a finding based upon those rules. (Tr., Pt. II, pp. 602)

He testified that the PRM "certainly applies to Medicare. Because Ohio has deemed it in part of the hierarchy of criteria, it applies to Medicaid too." Furthermore, he acknowledged that there is no section

in the PRM which applies only to Medicare or only to Medicaid and there is no wording in the PRM which says that one rule applies to Medicare and one rule applies to Medicaid. (Tr., Pt. II, pp. 484-86)

Mr. Hapchuk admitted he was not familiar with the rules applicable to Ohio's Medicaid cost reports and does not know what is allowable in Ohio cost reports. Moreover, he does not know any provision of the Ohio Revised Code or Ohio Administrative Code that applies to the reporting of Providers Choice and Strategic costs in the cost reports. (Tr., Pt. II, pp. 558, 560)

As a preliminary matter, Mr. Hapchuk stated that Medicare rules, including 42 CFR 413.100, do not apply in a prospective payment system (PPS).[18] In an attempt to understand the type of reimbursement system used in Ohio, prior to the hearing, he printed off a one-page document from the internet which listed the various reimbursement systems used in Ohio, using words such as retrospective, semi-prospective, prospective and pricing. There were no definitions for any of these terms and he acknowledged he could have a different definition than that used by Ohio. (Tr., Pt. II, pp. 520, 548-550, 561; State Exhibit 274)

He stated that a Medicare prospective payment system is one in which "payment is not dependent upon what costs they incur, it's dependent upon what type of

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[18] Throughout the hearing different witnesses used the terms "prospective" and "retrospective". At times the witness clarified how he/she used the term. An explanation of how Ohio used the various terms is set forth at pages 15-16 of the Report and Recommendation.

services they perform." Mr. Hapchuk gave the following example to explain the difference between retrospective and prospective:

> Normally cost reimbursement is retrospective, when I said you take the costs, put them on a piece of paper, give it to the government, and then they do something and they determine liability, pay you. Prospective to me is the PPS system whereby . . . the government says I'm going to give you a thousand dollars for each appendectomy .... [TJhe amount of costs incurred by the provider is immaterial because I'm going to pay you on prices.

(Tr., Pt. II, pp. 540, 631)

Since in Ohio, in 2003, the rates were based upon the reported costs incurred, not the type of service performed, Ohio was not under a prospective payment system such as that described by Mr. Hapchuk and used by Medicare. He further explained that in a retrospective system, cost reports are utilized and the provider is required to report reasonable costs. He stated that this system was in place in Ohio in 2003 and that under Medicaid, "states have an option of how they want to reimburse. It appears Ohio had retrospective. They were reimbursing 100 percent of reasonable costs." (Tr., Pt. II, pp. 525-28)

Mr. Hapchuk stated that under the system Ohio had in 2003, the providers were to report their reasonable costs. He further testified that in reporting these costs, 42 CFR 413.100 and PRM 2305 would be applicable. In his auditing experience, he has applied

42 CFR 413.100 and PRM 2305 to cost report audits where the reported costs are used as a basis to reimburse the provider. (Tr., Pt. II, pp. 531,533, 535-36, 604)

Mr. Hapchuk, however, stated that reporting costs "is one thing and what is going to be reimbursed is another. One is putting a number on a document. The other one is how much cash you are going to actually get." When asked to separate what gets reported and what gets reimbursed, Mr. Hapchuk stated it was "very, very, very difficult to separate them" in this case. (Tr., Pt. II, pp. 534, 535)

He was asked to look at the invoice from Strategic to Carington Park for the Enhanced Services. Mr. Hapchuk stated he had not seen this document or any of the other invoices for these services. He had, however, looked at the promissory notes. Mr. Hapchuk was asked whether the invoice, which stated "Payment due upon receipt of invoice", was a short-term liability. Mr. Hapchuk responded, "I don't think I'm prepared to stipulate to that." He went on to explain:

> Well, when you talk about short-term and long-term liabilities, and everybody keeps talking about one year, and I agree there's a one-year rule, but in my mind, who determines if something is a liability? And I really don't know, to tell you the honest truth. I don't know if this was booked by Carington as a short-term liability; if it was treated as a payable, which meant it never hit the books. What I do know is that eventually both Carington and the other ones thought of it as a long-term promissory

> note....I'm not sure I understand the rules for it, frankly.

(Tr., Pt. II, pp. 574-75; State Exhibit 59)

Mr. Hapchuk was presented with a scenario in which he might be serving as an auditor and was provided with 1) a contract indicating services rendered between January 1, 2003 and December 31, 2003 and 2) a corresponding invoice for these services, dated December 31, 2003, and stating the invoice is payable upon receipt. He was asked whether the invoice was a short-term liability. He responded that "the reason I don't want to do it is I understand what these data are going to be used for." He further stated that "Carington didn't cause the State to convert over to a PPS system....My whole thing on this is nobody has questioned that these consulting services were true, valid, related to patient care. ... And my feeling is, okay, so you know, if they had kept the cost reimbursement system, I'd probably have a different idea." Mr. Hapchuk then stated that his "judgment is, hey, I don't see any harm here, quite frankly. I don't." (Tr., Pt. II, pp. 579-80)

Then ODM's counsel asked him to look at the Strategic and Providers Choice contracts for services and whether they are reportable in a calendar year 2003 cost report. Mr. Hapchuk replied that he was unable to do so for a Medicaid cost report. (Tr., Pt. II, pp. 590)

He later acknowledged that the invoice for Enhanced Services was due upon receipt, which is less than one year, and the definition of a short-term

liability is a liability that is due in less than one year. He further admitted that according to 42 CFR 413 .100, a short-term liability should be liquidated within a year. He was then asked whether the promissory note, which is a negotiable instrument, is liquidating the short-term liability of the invoice. He agreed that the promissory note was liquidating something, that it was liquidating a liability. But he could not say whether the liability was short-term or long-term. (Tr., Pt. II, pp. 593-96)

It is noted that in his written expert report, Mr. Hapchuk wrote: "a short-term liability such as the money due Strategic and Providers was paid in the form of the delivery of 3 year promissory notes...." He also wrote: "Payment of the short-term liabilities due Strategic and Providers Choice was completed when the promissory notes were signed and delivered to those companies." Mr. Hapchuk went on to say that "Since the execution and delivery occurred before December 2004 the short-term liability was timely liquidated." (Respondent Exhibit NNNN, pp. 4, 6, 7)

He opined that, based upon the facts presented to him in this case, the Liquidation of Liabilities Rules does not apply. He stated, however, if Ohio's reimbursement system had not changed, he would have a different opinion. "Under the old system, the State would pay for something, a cost for 2003 when it was actually liquidated. They would have paid for it eventually." (Tr., Pt. II, pp. 503, 514-15, 517)

Reds Tickets

Terrace View Gardens, Franklin Ridge, East Galbraith Health Care Center, Glen Meadows and Wellington Manor reported on their 2003 cost reports the costs associated with the purchase of 2004 Cincinnati Reds season tickets. State Exhibit 41 is an invoice for season tickets Cincinnati Reds games to Joe Tucker, 2470-1/2 Princeton Pike Rd., Hamilton, Ohio. The tickets were for the 2004 baseball season. There was no evidence as to who Joe Tucker is and/or what, if any, affiliation he has with CHS. These costs were reported in the "employee benefits" accounts.[19] (Tr., Pt. II, p. 146; State Exhibit 268, p. 3; State Exhibit 41)

PRM, CMS Pub. 15-1, section 2105.8 states: "Costs incurred by providers for entertainment, including tickets to sporting or other events, ... are not allowable." Mr. Cummins stated: "The Reds tickets were classified as employee benefits. They were used for the staff of the Cincinnati-based facilities. Carington Health System had a policy that was in writing, and had been established as to what it was going to be used for." No such policy was identified during the hearing. In Respondent Exhibit VV, however, an undated single page document was found, titled "Cincinnati Reds Season Ticket Policy." There was no indication where this document came from; there was no number on the page (other than the exhibit page number) which might indicate that that it came from an employee manual or some other type of

[19] Cost accounts 6530, 7070 and 7520 are employee benefit accounts. (Tr., Pt. II, p. 146)

employee benefit package material. There were no initials indicating that the auditors saw the document during the audit. Therefore, there is no way of knowing when this document was created. When asked at the hearing if there was a continuous string of payments over the years for Reds tickets for employee benefits, Mr. Cummins responded, "I would imagine so." (Tr., Pt. II, pp. 777-78, 780; Respondent Exhibit VV, p. 2)

Ms. Hess stated in the few instances where this has occurred in Ohio, the auditors sought counsel from the State on how to handle a cost of sporting tickets under employee benefits. She said since the rule specifies that the benefit has to be nondiscriminatory, i.e. available to all, Ohio has instructed the auditors that the cost is allowable if documentation is provided as to which employees attended the game. Ms. Hess acknowledged that there is no specific rule that requires the names of employees. She said that although the regulations deny tickets altogether, Ohio gives a little leeway and will allow it as an employee benefit if there is documentation to show that the tickets are available to all employees, not just the owners and their friends. Although Mr. Cummins said the tickets were not used for the benefit of the owners, no documentation or other evidence to support this statement was produced. (Tr., Pt. II, pp. 147-49, 164, 782)

Furthermore, Ms. Hess also testified that employee benefits which are included in a cost report must be conferred during the cost-reporting period. Any benefit purchased or paid for in 2003 and included in the 2003 cost report must be used by the employee during that year. The tickets at issue were purchased in 2003 and

used during 2004. Therefore, if, in fact, the tickets were an employee benefit, they would only be an allowable expense if they were used in 2003. (Tr., Pt. II, pp. Hess, p. 148)

Mr. Cummins was asked if this was a valid basis for disallowance of the cost on the cost report. He responded that if something is reported in the wrong period, if it was reported in 2003 and should have been reported in 2004, the way that matter was resolved was to put the cost "in the more appropriate period." He stated, however, that in this case, because of the legislative change, this cost could not have been "pushed forward." (Tr., Pt. II, pp. 779-80)

Analysis

Audit/Agreed-Upon Procedures

Nursing home Medicaid providers are required to file annual cost reports with the Department. These cost reports, which "capture the costs and expenses incurred [during the year] for providing services to residents within the facility," are used to determine reimbursement for nursing home Medicaid providers. Nursing homes are required to maintain records to support the costs included in the cost reports, including financial, medical and statistical. "In the Medicaid audit setting, a provider must provide supporting documentation that demonstrates that the reported cost was actually incurred, that it is reasonable, allowable and related to patient care." *Meadowwood Nursing Facility v. Ohio Dept. of Job and Family Servs*, (10th Dist. 2005), 2005-Ohio-1263 at ¶19. (Tr., Pt. I, p. 130)

Pursuant to R.C. 5111.27, the Department is authorized to audit cost reports. These audits may be conducted by auditors under contract or ones employed by the Department. If the Department elects to use contract auditors, the contracts shall be entered into by bidding. With respect to the audits in this matter, the Department issued a Request for Proposal and Clifton Gunderson was one of the vendors selected to perform the cost report audits.

Pursuant to Ohio Admin. Code 5101 :3-1-27(B)(l), an audit is

> A formal post payment examination made in accordance with generally accepted accounting standards, of a Medicaid provider's records and documentation to determine program compliance, the extent and validity of services paid for under the Medicaid program and to identify any inappropriate payments.

The Department has conducted the audits of cost reports pursuant to Agreed-Upon Procedures since 1999. Respondent, however, contends that Agreed-Upon Procedures used by Clifton Gunderson do not constitute an audit. In support of its position, Respondents point to the testimony of Emily Hess who stated that some procedures for performing an audit are different than those under Agreed-Upon Procedures.

Ms. Hess explained that the use of the term "audit" has different meanings. She stated that under the auditing standards, "which is where the financial-based audits come from, there are specific standards that

have to be applied to those auditing standards." She stated that many judgment calls need to be made, such as control analysis or risk analysis. The primary purpose for financial-based audits is to enable people to look at the financial statements to make a decision on, for example, stock exchange or banks making loans. There are many purposes for an audit of a financial statement. (Tr., Pt. I, p. 523)

Under the auditing standards for governmental entities or entities receiving government funds such as Medicaid, however, there are attest standards. These standards are at a different level than financial based audits because the purpose of the audit of a governmental entity/entity receiving government funds is different. In the audits at issue in this case, the auditors were looking at specific information for a purpose – the impact of the cost report on the rate. Therefore, in these audits the purpose is to ensure that the costs included in a cost report are correct, documented, reasonable and allowable. In a cost report, the auditors are not looking at internal controls, inventory, accounts payable or cash status. (Tr., Pt. I, pp. 523-24)

The Independent Accountant's Report on Applying Agreed-Upon Procedures, "has specific language that is required under AICPA standards for attestation statement engagements compared to the auditing standards." For example, under the attestation standards, no representation can be made as to the sufficiency of the procedures because Clifton Gunderson did not write them, and, therefore, Clifton Gunderson cannot "take ownership of them as a CPA

firm." The report states: "This agreed-upon procedures engagement was performed in accordance with attestation standards established by the American Institute of Certified Public Accountants." (Tr., Pt. I, pp. 523-25; Respondent Exhibit RR, p. 1176)

In advancing its argument that an audit was not performed in this case, Respondent cites two cases, *Medcorp, Inc. v. Ohio Dept. of Job and Family Services* (10th Dist., 2008) 2008-Ohio-464 and *HCMC, Inc. v. Ohio Dept. of Job and Family Services, (10th Dist. 2008)179 Ohio App.3d 707*, which found proper audits had not been performed. Neither of these cases, however, concern cost report audits and are, therefore, not relevant to the herein matter. The issue in *Medcorp* concerned the use of statistical sampling methodology used by the Department to extrapolate the results of a small sample of claims to a larger sample. The Court in *Medcorp* found that the sampling methodology used by the Department and its application to the audit of Medicaid claims for medical transport was invalid. There is no issue of sampling in the herein case. *HCMC* concerned Medicaid payments on a fee-basis. HCMC, an oxygen supply company, provided services to Medicaid and non-Medicaid patients, billing the patients in different ways and at different rates. Again, the issues in *HCMC* are completely different than those in the herein case.

The issue of cost report audits, however, was specifically addressed by the Tenth District in *St. Francis Home, Inc. v. Ohio Dept. of Job and Family Services (10th Dist. 2006)* 2006-Ohio-6147. The Court stated that "R.C. 5111.27(B) provides that the scope of

an audit conducted is within the discretion of ODJFS." *Id*. at ¶25 Furthermore, the factors set forth in R.C. 5111.27(B) "embody the standards that the audits be conducted in a manner to produce an accurate result and ODJFS utilize auditing procedures that are objectively verifiable." *Id*. at ¶21. Moreover, the Court held that under R.C. 5111.27(B), the Department shall consider accepted auditing standards and even if the auditors did not comply with generally accepted auditing standards the audit is not rendered invalid. *Id*. at ¶ 23

The audit manual and program for audits of cost reports is to include the following:

(1) Comply with the applicable rules prescribed pursuant to Titles XVIII and XIX;

(2) Consider generally accepted auditing standards prescribed by the American institute of certified public accountants;

(3) Include a written summary as to whether the costs included in the report examined during the audit are allowable and are presented fairly in accordance with generally accepted accounting principle and department rules, and whether, in all material respects, allowable costs are documented, reasonable, and related to patient care;

(4) Are conducted by accounting firms or auditors who, during the period of the auditors' professional engagement or

employment and during the period covered by the cost reports, do not have nor are committed to acquire any direct or indirect financial interest in the ownership, financing, or operation of a nursing facility or intermediate care facility for the mentally retarded in this state;

(5) Are conducted by accounting firms or auditors who, as a condition of the contract or employment, shall not audit any facility that has been a client of the firm or auditor;

(6) Are conducted by auditors who are otherwise independent as determined by the standards of independence established by the American institute of certified public accountants;

(7) Are completed within the time period specified by the department;

(8) Provide to the provider complete written interpretations that explain in detail the application of all relevant contract provisions, regulations, auditing standards, rate formulae, and department policies, with explanations and examples, that are sufficient to permit the provider to calculate with reasonable certainty

> those costs that are allowable and the rate to which the provider's facility is entitled.

R.C. 5111.27(B)

As the court in St. Francis stated, "These requirements embody the standards that the audits be conducted in a manner to produce an accurate result and ODJFS utilize auditing procedures that are objectively verifiable." Therefore, if an audit is conducted in such a manner as to produce an accurate result and the procedures used are objectively verifiable, a valid audit is performed. Agreed-Upon Procedures, which the Department has utilized since 1999, set forth the scope and method to be utilized in conducting the cost report audits. The auditors must indicate the steps taken and provide work papers documenting their work to verify their findings. *Id*. at ¶21.

Respondent argues that Clifton Gunderson did not complete the Agreed-Upon Procedures and presents several bases for its contention.

First, Respondent states that "the most fundamental flaw in the procedures performed by Clifton Gunderson is the obvious lack of independence by the auditors." (Post-hearing Brief of Appellant (Phase I) at 9) In support of its argument that Clifton Gunderson lacked independence, Respondent noted that in its response to the RFP, Clifton Gunderson included Mr. Wilkins, former chief of the Department's Bureau of Audit, as a reference. However, since Clifton Gunderson had performed hundreds of cost report

audits for the Department, Mr. Wilkins was familiar with Clifton Gunderson's work and would be an appropriate reference.

The issue of independence is an important factor. Therefore, R.C. 5111.27(B) specifically states that the accounting firm performing the audit 1) shall not audit any facility that has been a client of the firm or auditor and 2) the firm not have direct or indirect financial interest in a nursing facility. These factors concern independence from the entity being audited, not from the Department. Moreover, R.C. 5111.27 authorizes the Department to use its own employees to perform cost report audits. The employees are obviously not independent from the Department.

Respondent also claims that Clifton Gunderson could not be independent because in its response to the RFP, Clifton Gunderson stated that it found a 5:1 return-on-investment ratio for prior audits. Therefore, argues Respondent, "it is difficult to imagine how this auditing firm will perform work truly independently and not driven by the incentive to at least meet this prior ration." (Post-hearing Brief of Appellant (Phase I) at 9-10) Since any disallowance that an auditing firm finds in a cost report audit must be substantiated with documentation, the nursing home is protected from any unsupported finding.

Second, Respondent argues that Clifton Gunderson departed from the Agreed-Upon Procedures outlined in the RFP. After being awarded the contract and prior to commencement of work, Clifton Gunderson requested a slight modification to the cash disbursement testing. This request was granted and approved by Mr. Wilkins

prior to any work being performed under the contract. Although Mr. Wilkins stated that he would have documented that modification in an email or letter, no such document was produced at the hearing. Ms. Hess testified that Clifton Gunderson completed the Agreed-Upon Procedures, which included the modification requested before they commenced work. (Tr., Pt. I, pp. 185-87, 260-61, 497)

Third, Respondent argues that Clifton Gunderson departed from the Agreed-Upon Procedures because it did not obtain a signed representation letter from CHS. The record is clear that Clifton Gunderson attempted to obtain signatures from Wellington Manor, Terrace View Gardens and Glen Meadows, but they refused to provide signatures. (Tr., Pt. I, pp. 582-83, 679-80)

Mr. Cummins testified that the AICPA standards regarding the performance of Agreed-Upon Procedures "specifically state that if the accountant cannot obtain a management representation letter from a responsible party, they are required to withdraw, and there is no exception. They are required to withdraw." In this case, the practitioner is Clifton Gunderson, the responsible party is CHS and the client is the Department. (Tr., Pt. I, pp. 561,585, 588)

AICPA AT section 201.39 states:

> The responsible party's refusal to provide written representation determined by the practitioner to be appropriate for the engagement constitutes a limitation on the performance of the engagement. In such circumstances, the practitioner should do one of the following:

a. Disclose in his or her report that inability to obtain representation from the responsible party.

b. Withdraw from the engagement.

c. Change the engagement to another form of engagement.

Furthermore, AT section 601.13 states "If, in an agreed-upon procedures engagement, the practitioner's client is not the responsible party, the practitioner is not required to withdraw but should consider the effects of the responsible party's refusal on the engagement and his or her report." Therefore, Clifton Gunderson was not required to withdraw from the audit. Moreover, Clifton Gunderson notified their client, the Department, that Respondents refused to sign the representation letter. (State Exhibit 20, p. 3)

Fourth, CHS argues that Clifton Gunderson did not complete the engagement. After the exit conference between CHS and Clifton Gunderson, Clifton Gunderson requested additional documentation, some of which was subsequently provided. After reviewing these documents, Clifton Gunderson incorporated the relevant information into the audit results, revised the disallowances, and submitted the Audit Input Document, copy of the proposed cost adjustments and papers, thus completing the audit. (Tr., Pt. I, pp. 311, 316)

Fifth, Respondent contends that the basis upon which disallowances due to related party issues were made were inadequate. These disallowances were also based upon lack of documentation. Moreover, the issue

of appropriateness of individual cost adjustments was to be addressed in Phase II of the hearing. (Tr., Pt. I, pp. 515-16)

Sixth, although Respondents acknowledge that "lack of documentation is a valid criterion for disallowing costs," (Post-hearing Brief of Appellant (Phase I) at 15) they argue that Clifton Gunderson was at fault for failing to contact Bert Cummins about the difficulties in obtaining documentation. The nursing home facility is required to maintain adequate documentation to substantiate its costs. It is incumbent upon the facility being audited to produce the documentation to support the costs included in cost reports. Respondents were given months to collect the information requested by Clifton Gunderson. They failed to do so. They cannot now turn around and say the audit is invalid because the auditor did not have sufficient information to complete the audit.

Seventh, Respondents contend that all proposed adjustments were not discussed with Respondent at the exit conference with Clifton Gunderson. CHS bases its argument upon the fact that the second page of the form documenting the exit interview was not filled in. This second page has three sections: "Proposed Adjustment Areas", "Document agreement and/or disagreement with the proposed adjustments and any pertinent comments below", and "Were work papers given to the provider? If yes, please indicate which work papers." However, David McClellan, CHS' Corporate Controller, signed the first page of the form, which states: "All of the proposed adjustments known at this time were discussed with the Provider and a

copy of the proposed adjustments was given to the Provider." Additionally, CHS was given a list of outstanding documents and records requested but not received. (State Exhibit 9, Terrace View, p. 371)

Finally, Respondent contends that the audit conducted by Clifton Gunderson was inconsistent with others it had conducted and with an audit conducted by another firm, Tichenor & Associates. Respondent argues that, since Clifton Gunderson always performed its engagements in the same manner, the results regarding related party transactions should have been the same. In the audits at issue, however, one of the issues with the related party transactions was a lack of documentation. It is unknown what type of documentation the auditors in the previous audits received from CHS. Respondent also argues that Tichenor conducted an audit of a three-month period which was also included in the period Clifton Gunderson's audit and "made no adjustments for any home office costs associated with Strategic or Provider's Choice." (Tr., Pt. I, p. 319; Post-hearing Brief of Appellant (Phase I) at 18)

As a preliminary matter, it is unknown what documents CHS produced to Tichenor. Furthermore, as the Tenth District responded to a similar argument raised in *Meadowwood* , 2005-Ohio-1263, "the other years are irrelevant here. ODJFS could have mistakenly allowed the expense." *Id*. at ¶29, In other words, prior audits do not bind subsequent audits. As a final matter, it is interesting that CHS is asserting that Tichenor performed an audit, since the Agreed-

Upon Procedures used by Clifton Gunderson were the same as those used by Tichenor. (Tr., Pt. I, pp. 673-74)

Respondent also argues that it did not receive an exit conference. However, the exit conference was held between Respondents and Clifton Gunderson's auditors on June 16, 2003. What Respondents did not get was a final fiscal audit conference, which may be held after a proposed adjudication order is issued. There is no requirement for the Department to hold these conferences.

In conclusion, the Agreed-Upon Procedures performed by Clifton Gunderson in the cost reports at issue herein constitute an audit for purposes of R.C. 5111.27.

Direct Care and Indirect Care Consulting Costs

The parties entered into contracts with Providers and/or Strategic for services for 2003. The Stipulation of the Parties ¶¶ 6 and 7, attached hereto as Attachment C, set forth the relevant contracts. These contracts consisted of two parts: those outlined in the main body of the contract, ("Annual Services") and an attachment to the contract ("Enhanced Services").

In analyzing whether the costs, which were not paid within one year of the end of the cost reporting period, are reasonable and allowable, it is necessary to look at the provisions of the CFR and PRM, specifically 42 CFR 413.100 and PRM 2305 (collectively, "Liquidation of Liabilities rule").

The Federal Register, which provides some guidance in interpreting the CFR, states that 42 CFR

413 codifies the long-standing policy regarding "the timing of payment for accrued costs by requiring timely liquidation of liabilities [to receive payments]. This policy is intended to prevent the outlay of federal trust funds before they are needed to pay the costs of providers' actual expenditures."[20] (60 Fed. Reg. 33129 (June 27, 1995))

Moreover, "[t]he purpose of the regulation [42 CFR 413] is to assure that Medicare recognizes only costs associated with a liability that is timely liquidated through an actual expenditure of funds. GAAP does not offer this assurance for Medicare." In another comment, it states that "in the absence of timely liquidation of the liability, the cost can be claimed in the cost reporting period when the liquidation occurs, that is, when actual expenditure takes place, as currently described in section 2305 of the Provider Reimbursement Manual." (60 Fed. Reg. 33131 (June 27, 1995); State Exhibit 272,p. 6)

Respondents, however, contend that although the CFR and PRM are part of the hierarchy of rules which apply in Ohio in determining appropriate costs in cost reports, these particular provisions of the CFR and PRM do not apply to Medicaid cost reports. Furthermore, Respondents argue that the liability created by the contracts for Enhanced Services and the subsequent invoices for such services are not a short-

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[20] It is noted that this comment addresses Medicare. Ohio, through its hierarchy of authorities, has adopted the CFR and PRM for its Medicaid program.

term liability, and, therefore, 42 CFR 413.100 and PRM 2305 do not apply.

First of all, Respondents argue that 42 CFR 413.100 does not apply in a prospective payment system. The Background section of the Federal Register commenting upon 42 CFR 413.100, states that this section does not apply to Medicare providers under a prospective payment system. 60 Fed. Reg. 33126 (June 27, 1995) Mr. Hapchuk described the Medicare prospective payment system as one in which "payment is not dependent upon what costs they incur, it's dependent upon what type of services they perform." Furthermore, Mr. Cummins stated that under a prospective payment system, nursing homes are reimbursed at a flat rate for each RUG (Resource Utilization Group) category, regardless of the cost to the facility. The flat rate is per service rendered regardless of cost. (Tr., Pt. II, p. 879)

From fiscal year 1994 through fiscal year 2005, Ohio was on a prospective cost-based system. In this system, Ohio reimbursed nursing home facilities based upon their actual reasonable costs, which were used to establish the per diem rate for the next fiscal year. Mr. Hapchuk acknowledged that Ohio's system during this period was not a prospective payment system as used under Medicare. The providers in Ohio were reimbursed based upon costs incurred rather than service provided, thereby distinguishing Ohio's prospective cost-based system from the Medicare prospective payment system. Accordingly, Respondents' argument that 42 CFR 413.100 and PRM 2305 do not apply to 2003 cost reports based upon the

reimbursement system in effect at the time is not well-taken.

Respondents also argue that the Liquidation of Liabilities rule, which addresses short-term liabilities, does not apply to the Enhanced Services contracts because the liability is not short-term.

42 CFR 413.100 addresses special treatment of certain accrued costs. The rule states that "under the accrual basis of accounting, revenue is reported in the period in which it is earned and expenses are reported in the period in which they are incurred." However, for "the accrual of costs for which a provider has not actually expended funds during the current cost reporting period," the rule then sets forth requirements for liquidation of liabilities. If these requirements are not met, the cost is disallowed, generally in the year of accrual, except as specified in another portion of the rule which does not apply to this case.

One type of accrued cost addressed in 42 CFR 413.100 is a short-term liability. Specifically, "a short-term liability, including the current portion of a long-term liability (for example, mortgage interest payments due to be in the current year), must be liquidated within 1 year after the end of the cost reporting period in which the liability is incurred." A short term liability is one that is due and payable within one year of its occurrence. (Tr., Pt. II, pp. 42, 113, 240; 42 CFR 413.100(c)(2)(i)(A))

Respondent contends that the invoices for the Enhanced Services Contracts for services to be provided in 2003 were not short-term liabilities. In

accordance with the terms of the Enhanced Contracts, on December 31, 2003, Strategic and Providers billed the CHS facilities for the entire amount of the Enhanced Services portion of the contract. The invoice stated "payment due upon receipt of invoice." That same day, December 31, 2003, CHS facilities entered into promissory notes with Strategic and Providers for the full amount of these invoices. The promissory notes stated that payments would not commence until mid-2005.

The Department contends that the December 31, 2003 invoices for Enhanced Services, payable on receipt, are short-term liabilities. Respondents argue that the debt for the Enhanced Contract was a long-term debt and the promissory notes liquidated the debt.

The witnesses disagreed on whether the debt was a short-term and long-term liability. Mr. Cummins said the Enhanced Services contracts were long-term. Ms. Hess said they were a short-term liability. Mr. Hapchuk was unable to state whether the Enhanced Services invoices were long-term or short term liabilities. At one point in his testimony, when asked if an Enhanced Service contract was a short-term liability, he did not want to answer that question because he understood "what these data are going to be used for" and then stated that CHS did not cause the legislature to change the reimbursement system. He did state that the promissory note was liquidating a liability, but he could not say whether the liability was short-term or long-term. Although he stated "who determines when a liability is a liability?" he did

acknowledge that the invoice was a liability. When asked when the liability was due, he responded, "Half of the train says due upon receipt, and I don't know eventually it came up it was a long-term promissory note." In his written expert report, however, Mr. Hapchuk wrote: "a short-term liability such as the money due Strategic and Providers was paid in the form of the delivery of 3 year promissory notes...." He also wrote: "Payment of the short-term liabilities due Strategic and Providers Choice was completed when the promissory notes were signed and delivered to those companies." Mr. Hapchuk went on to say that "Since the execution and delivery occurred before December 2004 the short-term liability was timely liquidated." (emphasis added) (Tr., Pt. II, pp. 575, 577-78, 593-96, 913; Respondent Exhibit NNNN 4, 6, 7)

Mr. Fleischer stated that if an invoice is due immediately, it is a short term liability. He was shown a copy of an invoice dated December 31, 2003 from Strategic to Carington Park for Enhanced Services. This invoice stated "Payment Due Upon Receipt of Invoice." Mr. Fleischer testified that it was a short-term liability. (Tr., Pt. II, pp. 242, 278; State Exhibit 59, p. 4)

Respondents, however, argued that the statement on the invoices saying "due upon receipt" is irrelevant and has no meaning. It is merely form over substance and is a statement put on all of Strategic and Providers Choice invoices. On the same date as the invoices, CHS issued promissory notes for the entire amount of the invoice. If the invoices were not due upon receipt,

however, there would be no need to immediately issue the promissory notes.

Accordingly, the December 31, 2003 invoices for Enhanced Services are short-term debts. Having found that the invoices for the Enhanced Services were short-term liabilities, it is necessary to look at the provisions of 42 CFR 143.100 and PRM 2305, which address the liquidation of liabilities of short-term liabilities.

The CFR provision requires that a short-term liability must be liquidated within one year after the end of the cost reporting period in which the liability is incurred. The CFR, however, does not define what the term "liquidate" means. Therefore, according to the hierarchy of authorities, it is necessary to look to the PRM. The Provider Reimbursement Manual, CMS HIM-15-1, section 2305 is consistent with the CFR, but sets forth additional requirements regarding short-term liabilities. In addition to requiring that the short term liability be liquidated within one year after the end of the cost reporting period, the PRM requires:

> Liquidation must be made by check or other negotiable instrument, cash or legal transfer of assets such as stocks, bond, real property, etc. Where liquidation is made by check or other negotiable instrument, these forms of payment must be redeemed through an actual transfer of the provider's assets within the time limits specified in this section. Where the liability (1) is not liquidated within the 1-year time limit, or (2) does not qualify under the exceptions

> specified in §§2305.1 and 2305[21], the cost incurred for the related goods and services is not allowable in the cost reporting period when the liability is incurred, but is allowable in the cost reporting period when the liquidation of the liability occurs. (emphasis and footnote added)

Therefore, it is necessary to determine whether the liability or debt set forth in the invoices for Enhanced Services was (1) liquidated within one year of the end of the cost reporting period and (2) whether that liquidation complied with the requirements set forth in PRM 2305.

Respondents argued that promissory notes are used extensively in commercial transactions. The issue in this case, however, involves more than a commercial transaction or mere payment of a debt and accord and satisfaction. As stated in the Federal Register, the purpose of the Liquidation of Liabilities rule is to ensure that "costs associated with a liability are timely liquidated through an actual expenditure of funds." (emphasis added) Recognizing that this purpose is different than that involved in mere commercial transactions, the Federal Register points out that "GAAP does not offer this assurance." (60 Fed. Reg. 33131 (June 27, 1995)) PRM 2305 sets forth specific criteria to be met in order to liquidate a liability or a debt for purposes of cost reporting.

Pursuant to PRM 2305, liquidation must be made:

1) by check or other negotiable instrument; and

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[21] These exceptions do not apply in this case.

> 2) where liquidation is made by check or other negotiable instrument, these forms of payment must be redeemed through an actual transfer of the provider's assets within one year from the end of the cost reporting period in which the expense was incurred.

If both of these criteria are not met, then the "cost incurred for the related goods and services is not allowable in the cost reporting period when the liability is incurred, but is allowable in the cost reporting period when the liquidation of the liability occurs." Therefore, if both of these criteria were not met, the costs for the Enhanced Services contracts should be disallowed in the 2003 cost report.

Having made payment of the December 31, 2013 invoices for Enhanced Services through promissory notes, which are negotiable instruments, CHS complied with the first portion of the rule. Therefore, pursuant to the wording of PRM 2305, the payment, i.e. the promissory note, must be redeemed through an actual transfer of CHS' assets within one year from the end of the cost reporting period, which was December 31, 2004.

Mr. Fleischer testified that the promissory notes did not transfer assets from CHS to Strategic.[22] Rather, Strategic took the notes in lieu of cash. They did, however, liquidate the liability for purposes of GAAP and reporting financial statements of the company. He said that the promissory note given by Carington to

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[22] These comments applied to all Enhanced Services contracts and promissory notes.

Strategic is an asset of Strategic. It is not an asset of Carington. He said that the amount of the promissory note would show as an asset on Strategic's balance sheet. (Tr., Pt. II, pp. 259-61, 266)

There is a difference, however, between what is reported in a financial statement and what is reported in a cost report. Ms. Hess stated that the provisions of 42CFR 413.100 and PRM 2305 place additional requirements for reporting costs in a cost report that do not exist for reporting on a financial statement. The financial statement is only required to follow GAAP, not the CFR or PRM. (Tr., Pt. II, pp. 963-64)

The Federal Register emphasizes that

> GAAP and Medicare payment policy have different purposes. Unlike GAAP, which is intended to be used to present the financial position of an organization, Medicare policy specifically deals with paying providers for costs incurred in furnishing care to Medicare beneficiaries. For payment purposes, the Medicare Trust Funds should not be required to pay a provider for costs associated with liabilities that are not liquidated timely.

60 Fed. Reg. 33129 (June 27, 1995)

Mr. Fleischer consistently stated that the liability of the invoices for the Enhanced Services were liquidated when the promissory notes were issued. He acknowledged that when Strategic deposited CHS' first payment on the promissory note, however, a transfer of funds occurred. (Tr., Pt. II. Pp. 269-70)

In Medical Rehabilitation Services P.C. v. Bowen, U.S. Dist. Ct., E.D. Michigan, No. 87-CIV-75547-DT, 1989 WL 146308 (Sept. 6, 1989), the Court was faced with a situation in which the provider included the full expense ($61,544) of a deferred compensation package[23] in its cost report. However, the provider paid $17,330 by check and tendered its creditor a promissory note for the balance. In interpreting the PRM 2305, the Court held that "the issuance of a promissory note is not evidence of a liquidation, unless Plaintiff's assets were actually transferred to its creditor within one year of accrual." *Id*. at *7

Another case in which providers issued promissory notes for compensation deferral is *Professional Rehabilitation Outpatient Services v. Health Care Financing Administration*, U.S. Dist. Ct., S.D. of TX, H-00-2526, 2001 WL 1910296 (December 7, 2001). 42 CFR 413.100(c)(iv) states: "accrued liability related to compensation of owners...must be liquidated within 75 days after the close of the reporting period in which the liability occurs." Professional Rehabilitation Output Services elected to defer payment of the salaries of four corporate officers and subsequently issued promissory notes to each of the officers, committing to pay on or before December 31, 1998. *Id*. at *3

The compensation costs were denied based on the liquidation of liabilities rule. The reasonableness of the

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[23] 42 CFR 413.100 addresses special treatment of certain accrued costs, including short-term liability, vacation pay and all-inclusive paid days off, sick pay, compensation of owners, nonpaid workers, FICA and other payroll taxes, deferred compensation and self-insurance.

costs was not disputed. In upholding the decision to disallow the costs, the court found that the provider failed to timely liquidate the liability because Professional Rehabilitation did not transfer any assets to pay off the promissory notes within the applicable time period. *Id*. at *6

CHS also failed to transfer assets for the promissory notes for Enhanced Services contracts within the requisite time period, and thus CHS failed to meet the two preconditions to reimbursement of costs related to a short-term liability.

In addition to the issues concerning the Enhanced Services contracts, CHS also had annual contracts in which some payments were not made timely pursuant to 42 CFR 413.100 and PRM 2305. Under the Annual Contracts, Strategic and/or Providers Choice submitted monthly invoices, payable upon receipt, to the CHS facilities. Most, but not all, of the invoices were paid within one year after the end of the cost reporting period. As set forth in the chart on pages 21-22 of the Report and Recommendation, seven invoices (6 from December 2003 and one from November 2003) from Strategic were not paid until 2005. Furthermore, one provider, East Galbraith, made late payments (i.e. more than one year after the cost reporting period) to Providers Choice for all of the services provided in 2003.

Mr. Fleischer was asked to assume that the check dated April 26, 2005, payable to Strategic Nursing

System, was payment for the November 2003 invoice.[24] He agreed that the costs associated with this invoice would not be reported in a 2003 cost report under the liquidation of liability rule. Since these costs were not liquidated within one year after the end of the cost reporting period, under the provisions of both the CFR and PRM, these costs are not allowable in the cost report. (Tr., Pt. II, pp. 243-44; State Exhibit 58, p. 23)

The amounts attributable to the payments for the Annual Contracts and which were paid after December 31, 2004 are set forth in State Exhibit 268, pp. 1, 2 (attached hereto as Attachment B)

As a final matter, CHS contends that the Liquidation of Liabilities rule should not even apply to the facts in this case because the Ohio legislature changed the type of reimbursement system in FY2006. CHS argues that it would be unable to recuperate its costs if they were not included in the 2003 cost reports.

Both Mr. Fleischer and Mr. Hapchuk testified that their opinions regarding the inapplicability of the Liquidation of Liabilities rule to the facts in this case were greatly influenced by the fact that the reimbursement system changed in July 2005. Mr. Hapchuk stated that if the system had not changed, his opinion would be different. (Tr., Pr. II, pp. 248-50, 301, 579-80)

Whether costs are allowable are determined by the law in effect at the time. Moreover, at the time of filing

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[24] The parties agree that the April 26. 2005 check was payment for the November 2003 invoice.

the 2003 cost reports, CHS did not know that the Medicaid reimbursement system would change in July 2005. A future change in the reimbursement system does not provide justification to ignore the cost reporting laws in effect at the time of filing cost reports.

Interestingly, in August 2004, before CHS made any payments on the promissory notes and before the reimbursement system changed, CHSHO Inc. purchased Strategic for $4.6 million, less than the amount of money CHS owed Strategic for the promissory notes at issue here. Mr. Cummins stated that because of this acquisition, CHS "owed the money to themselves." (Tr., Pt. II, p. 894) The monetary implications of this acquisition are unknown and are not relevant to a determination of whether the Enhanced Services costs are allowable in the 2003 cost reports, but may have an impact on concerns raised by Mr. Fleischer and Mr. Hapchuk. Moreover, the 2003 cost reports were used to set the reimbursement rate for FY 2005, a year before the new system went into effect.

The promissory notes at issue in this case total millions of dollars. It is clear that the first payment on the promissory notes were not made until 2005. Therefore, the first outlay of cash was not made by CSH until the beginning of FY2006. The per diem rate CHS received for FY2005, however, was based upon the 2003 cost reports, which included the amount of the promissory notes at issue in this case. Therefore, the figures used to calculate the per diem rate for 2005 included millions of dollars represented by the

promissory notes. Because of the deferred payment arrangement, however, CHS received Medicaid funds prior to actually expending any assets. It is scenarios such as this, where a provider receives government funds prior to expending the money for services, that 42CFR 413.100 and PRM 2305 were intended to prevent.

Cincinnati Reds Tickets

Based upon PRM 2105.8, the cost for season Cincinnati Reds tickets were disallowed. PRM 2105.8 states:

> Costs incurred by providers for entertainment, including tickets to sporting or other events, alcoholic beverages, golf outings, ski trips, cruises, professional musicians of other entertainers, are not allowable. Costs incurred by providers for purposes of employee morale, specifically, for an annual employee Christmas or holiday party, an annual employee award ceremony or for sponsorship of employee athletic programs (bowling, softball, basketball teams, etc.), are allowable to the extent that they are reasonable.

The rule clearly prohibits the reimbursement of tickets to sporting events. Respondents, however, argue that the season Cincinnati Reds tickets were not used for "entertainment," but were employee benefits, which, if reasonable, should be allowed. (Respondents' Post Phase II Merit Brief at 61) Mr. Cummins testified "if they're used for employee benefits, they're allowable if they are reasonable." (Tr., Pt. II, p. 778)

A close reading of the rule, however, does not say that costs of the prohibited items, such as sporting events, are allowable if reasonable. The rule states that costs incurred for employee morale, "specifically" listing the types of events or activities, are allowable if reasonable. None of the prohibited items are included in the listing of employee morale items, which are very different in character than the prohibited items.

Assuming arguendo that Respondents' interpretation is correct, if a provider wishes such prohibited expense to be considered an employee benefit, it is incumbent upon the provider to produce documentation to support such contention. No assumption can be made, as CHS argues, that merely because the cost of tickets were listed under employee benefits on the cost report and included as employee benefits, they were used by employees, as opposed to owners and their friends. Moreover, the unidentified piece of paper entitled "Cincinnati Reds Season Tickets Policy" and found in Respondent Exhibit VV is undated. There is no way of knowing when this document was created. (Respondents' Post Phase II Merit Brief at 62)

Moreover, employee benefit costs must be conferred during the cost reporting period. That was not the case here. Mr. Cummins acknowledged that if these costs were reported in the wrong period, the matter would be resolved by including them "in the more appropriate period." Again, as with the liquidation of liabilities issue, the change of legislation issue was raised as the reason the appropriate year could not be used. (Tr., P. II, p. 779)

For the above stated reasons, the cost for the 2004 Cincinnati Reds tickets should be disallowed and the corresponding adjustments in State Exhibit 268, p. 3 be adopted.

Notice Issue

The Liquidation of Liabilities rule was not cited in the Notice letters as a basis for disallowances. The basis for the disallowance at issue at that time was insufficient documentation to support the reported costs. Therefore, CHS argues that it did not receive notice that the Department was going to use the liquidation of liabilities rule to disallow costs. Specifically, Respondents state: "The intention to apply this rule was not included in the notices of opportunity for a hearing, nor in the audit reports or reports of final settlement attached to and incorporated in the notice of opportunity for a hearing. " Therefore, Respondents argue, "the liquidation of liabilities rule cannot be applied." (Respondents' Post Phase II Merit Brief at 27-28)

The due process afforded a respondent in an administrative hearing is the right to a reasonable notice of hearing and reasonable opportunity to be heard, including reasonable notice of the subject matter of the hearing. *State ex rel. LTV Steel Co. v. Industrial Comm'n of Ohio* (10th Dist., 1995) 102 Ohio App.3d 100, 103-04 The purpose of the notice requirement in R.C. 119.07 is to enable the respondent to prepare a defense. *Geroc v. Ohio Veterinary Med. Bd.* (8th Dist. 1987), 37 Ohio App.3d 192, 198; *Keaton v. Ohio Dept. of Commerce* (10th Dist. 1981), 2 Ohio App.3d 480,482-83

It was only after discovery in this matter that the Department received the documentation which revealed there was no actual transfer of CHS' assets within one year from the end of the cost reporting period. CHS, however, argues that the two-year (2003 and 2004) Combined Financial Statement of all the CHSHO and its Affiliates disclosed promissory notes paid by CHS to Strategic, and, based upon this, the auditors had sufficient information to make a determination on whether to disallow the costs under the liquidation of liabilities rule.

In advancing its argument, CHS relies upon Note L in the Combined Financial Statement of CHSHO and its Affiliates, stating:

> Carington contracted with Strategic Nursing Systems, Inc. (Strategic), to provide direct care consulting services....Additionally, at December 31, 2003 Carington owed Strategic $3,420,131, which was included in accounts payable-trade and accrued liabilities. At December 31, 2003, Carington also owed Strategic $12,082,000 of trade accounts payable that both parties agreed were not due within the next twelve months. This amount was classified as an other long-term obligation.

(Respondent Exhibit MMMM, p. 218)

Note A of the Combined Financial Statement of CHSHO and its Affiliates clarifies that "Carington" refers to CHSHO' Affiliates, stating: "The combined financial statements present the financial position, results of operations and cash flows of CHSHO, Inc.,

and Affiliates (Carington). The financial statements include the accounts of 21 affiliated Ohio corporations that operate under common management and are commonly owned. The corporate affiliates ... operate 35 long-term care facilities." Therefore, in Note L, "Caringtон" refers to 35 long-term care facilities. There is nothing in Note L which identifies which of the 35 facilities have promissory notes. Moreover, Ms. Hess stated that in order to determine which facility had the promissory notes it would be necessary to see the promissory notes prior to making a finding of disallowance of a cost in a cost report. (Tr., Pt. II, p. 986; Respondent Exhibit MMMM, p. 206)

During the audit, the auditors did not receive invoices for the Enhanced Services costs, promissory notes for the Enhance Services costs, or cancelled checks showing payments on the promissory notes. Without this information, the auditors would be unable to make a finding of failure to timely liquidate under PRM 2305. Ms. Hess testified that had they been given those documents, they "would have eliminated the cost based upon the Liquidation of Liability Rule which is Publication 15-1, Section 2305." (Tr., Pt. II, pp. 966-67)

It was only during the discovery stage of the administrative proceeding that the Department received documentation of these costs at issue on the Enhanced Services contracts.[25] The parties stipulated

[25] It is noted that during the discovery phase of this case, the Department received additional documentation on other allowances, which it reviewed and gave CHS credit, by removing some disallowances.

that, based upon documents received in the discovery process, the Department's "basis for the proposed disallowance of the costs reported in 6210 and 7215 is that the costs were not timely liquidated as provided by the provisions of 42 CFR §413.100 ... and the provisions of Pub. 15-1 §2305(A), §2305.1 and §2305.2." (Stipulation of the Parties, ¶ 8)

As stated in *Geroc* and *Keaton*, the purpose of the notice requirement in R.C. 119.07 is to enable respondent to prepare a defense. In this case, CHS knew the basis upon which the Department was proceeding and had time to thoroughly prepare its defense, including engaging experts and calling witnesses to address the liquidation of liabilities issues.

Respondent cites *Minges v. Ohio Dept. of Agriculture*, 213-Ohio-1808 (10th Dist. May 2, 2013) in support of its position that it did not receive proper notice. In that case, however, the Ohio Department of Agriculture (ODA) charged respondent with a rule that required ODA to prove a particular behavior. ODA, however, did not present evidence on this behavior and, in its closing argument, relied upon a rule not cited in the notice letter as the basis of its case. Therefore, respondent did not have any opportunity to prepare a defense.

In this case, CHS had ample opportunity to prepare and suffered no prejudice from the fact that the Notice Letter did not include notice of the disallowance under the liquidation of liabilities rule. See *Diso v. Dept. of Commerce*, 2012-Ohio-4672, ¶¶72, 73 (5th Dist. October 8, 2010) (finding respondent failed to show he was prejudiced; he had time to prepare his defense).

Moreover, to accept CHS' notice argument would encourage providers to fail to provide sufficient documentation during an audit, then produce the missing documentation during discovery and then require the Department to issue another notice of opportunity letter, starting the process all over again from the beginning.

Prior Use of Liquidation of Liability Rule

CHS argues that the liquidation of liabilities rule has never been used or interpreted in the manner the Department is doing in this case, and, therefore, the Department is precluded from using it in this case. CHS relies upon the testimony of Mr. Fleischer, who stated that, in his experience, he had not seen the rule applied in this manner. From this statement, CHS jumps to the conclusion that it has never been applied in this manner. (Respondents' Post Phase II Merit Brief at 46) The record in this case does not establish this fact one way or another.

Although CHS contends that the Department never applied the rule, it then argues that the Department has changed its application of the rule. CHS cites to *Cove Associates Joint Venture v. Sebelius*, 848 F. Supp. 2d 13 (D.D.C. 2012) to argue that a new interpretation of a rule cannot be applied to past practice. The court, however, required that the providers must prove they relied upon a prior interpretation of a rule. In this case, there is no evidence of a contrary prior interpretation or evidence that CHS relied upon a contrary interpretation.

CHS also raises the argument that the auditors are prohibited from applying the PRM 2305 as it relates to this case because it contends that the audit manual only referenced a liquidation of an owner-administrator compensation, not other types of liquidation of liabilities cited in 42CFR 413.100. During the hearing Mr. Cummins was asked to identify Respondent Exhibit QQQQ, which he identified as six selected pages from the audit manual that was in Clifton Gunderson's file. He said he went through the audit manual looking for references to liquidation of liabilities and this was the only reference he found. By including only one aspect of the rule, CHS argues, all other aspects or portions of the rule are excluded, under the *expressio unius* principle ("the expression of one thing is the exclusion of another"). (Tr., Pt. II, pp. 708-10)

Ms. Hess, however, stated that Respondent QQQQ was not part of the audit manual. It was part of a more comprehensive document, identified as State Exhibit 280, which was a listing of the most common adjustments made in audits. Moreover, she testified that the audit paragraphs listed in State Exhibit 280 are not an exclusive list and that the auditors would make adjustments for reasons other than those listed in State Exhibit 280. (Tr., Pt. II, pp. 948-50)

Furthermore, the auditors are required to apply all the laws according to the hierarchy set forth in Ohio Admin. Code 5101:3-3-0l(A).

Other Audits not at Issue In This Case

CHS also argues that there were other audits performed of other facilities in the CHSHO organization and no disallowance was made using the liquidation of liabilities in the manner it is being used in this case. A determination of whether a cost was allowable would depend, in part, upon the facts and documentation in each case.

One audit raised by Respondent in support of its position is that of East Galbraith, which covered the period of June 29, 2003- September 30, 2003. The Enhanced Service agreements and corresponding promissory notes, however, were not entered into until December 31, 2003. (Stipulation of the Parties, ¶7E) Furthermore, there is no evidence as to the documentation reviewed by the auditors in the other facilities.

Unpaid Days

Respondent contends that the hearing examiner improperly refused to consider evidence on unpaid days, including the admissibility of Respondent Exhibit 0000, which was therefore proffered. This matter was ruled upon in a March 15, 2013 Journal Entry granting the Department's Motion in Limine to exclusion evidence of unpaid patient days for room and board and unpaid claims for services.

Matters that are subject to R.C. Chapter 119 hearings are expressly limited to those matters authorized by statute. R.C. 5111.06 authorizes Chapter 119 hearings as a forum for providers to challenge matters included in final fiscal audits. The

statutory/regulatory scheme for final fiscal audits addresses the examination of payments by the Department, whether such payments were appropriate, and, if a determination of an overpayment is made, the requirements of notice to the provider and the provision of appeal rights under R.C. Chapter 119. The final fiscal audit is the end result of an audit, which was authorized by R.C. 5111.27, to determine whether the provider must refund an overpayment to the Department. Under this statutory/regulatory scheme, non-payment or unpaid claims are not subject to R.C. Chapter 119 proceedings. Unpaid days/claims which CHS wanted to adjudicate, are by definition not overpayments. Therefore, adjudication of claims for unpaid days and unpaid claims are not at issue in this administrative hearing.

Findings of Fact

To the extent any findings of fact constitute conclusions of law, they are offered as such.

1. The Respondents in this matter are: CHS-Glenwell, Inc. [Glen Meadows (provider number 2429330)]; CHS-Ohio Valley, Inc. [Terrace View Gardens (provider number 2339384)]; CHS-Glenwell, Inc. [Wellington Manor (provider number 2429321)]; CHS-Miami Valley, Inc. [Vandalia Park (provider number 2339624)]; CHS-Miami Valley, Inc. [Franklin Ridge (provider number 2339688)]; CHS-Greater Cincinnati, Inc. [East Galbraith Health Care Center (provider number 2399033)); and CHS-Lake Erie, Inc. [Carington Park (provider number 2339268)].

Respondents operate long-term care facilities, providing room, board and related nursing services to persons eligible for benefits under Ohio's Medicaid program. At the time at issue, ODJFS administered the Medicaid program pursuant to R.C. Chapter 5111 and Title XIX of the Social Security Act.

2. Initially, the cases involved in this matter were split between two hearing examiners. Originally, the above referenced hearing examiner was assigned CHS-Glenwell, Inc. Docket Nos. 09LTC17, 09LTC18, 09LTC19, CHS-Hamilton County, Inc. Docket Nos. 09LTC30, 09LTC31, 09LTC32, 09LTC33,[26] and Carington Health Systems Docket Nos. 09LTC24, 09LTC25[27]. Thereafter, the following cases were transferred to the above referenced hearing examiner and the parties agreed to consolidate the cases: CHS-Miami Valley, Inc. Docket Nos. 09LTC13, 09LTC14, 09LTC15, 09LTC16, 09LTC34, 09LTC35, 09LTC36, 09LTC37, CHS-Greater

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[26] During the hearing, the parties agreed that the correct name for CHS-Hamilton County, Inc. is CHS-Ohio Valley, Inc. and that the caption of the case be amended to reflect this change. They noted that throughout the proceedings the correct Provider No. was used for the entities. (Tr., Pt. II, pp. 23-4)

[27] During the hearing, the parties agreed that the correct name for CHS-Carington Health Systems is CHS-Glenwell, Inc. and that the caption of the case be amended to reflect this change. They noted that throughout the proceedings the documents the correct Provider No. was used for the entities. (Tr., Pt. II, pp. 23-24)

Cincinnati, Inc. Docket Nos. 09LTC20, 09LTC21, 09LTC22, 09LTC23, and CHS-Lake Erie, Inc. Docket Nos. 09LTC26, 09LTC27, 09LTC28, 09LTC29.

3. Prior to the consolidation, there were three days of hearings in the CHS-Glenwell, Inc. Docket Nos. 09LTC17, 09LTC18, 09LTC19, CHS-Hamilton County, Inc. Docket Nos. 09LTC30, 09LTC31, 09LTC32, 09LTC33, and Carington Health Systems Docket Nos. 09LTC24, 09LTC25 cases to address Respondents' challenge that the Department had not conducted audits. After consolidation, the parties agreed that the determination of whether an audit was conducted would apply to all the cases in consolidated case.

4. The Medicaid cost reports at issue in this matter are: 1) the calendar year 2003 Medicaid cost reports filed by Carington Park, Terrace View Gardens, Vandalia Park, and Franklin Ridge; 2) the six-month cost report covering July 1, 2003, to December 31, 2003, filed by East Galbraith Health Care Center; and 3) the three-month cost reports covering December 1, 2003, to February 29, 2004, filed by Glen Meadows and Wellington Manor. The cost reports are collective referred to as "2003 cost reports."

5. In order to conduct an audit of a cost report, the person(s) conducting the audit reviews records and documents to ensure that the

amounts reported in a provider's annual cost report are reported accurately, are allowable, documented, related to patient care and reasonable. Each cost in a cost report should be verifiable through documentation.

6. ODJFS issued a Request for Proposal (RFP) seeking independent professional auditors to audit the 2003 Cost Reports in accordance with Agreed-Upon Procedures. One of the firms selected was Clifton Gunderson, which has performed cost report audits since the Medicaid program began in the mid-1960's and has performed them for the Ohio Medicaid program pursuant to Agreed-Upon Procedures since 1999.

7. Clifton Gunderson contacted CHS on March 1, 2006, over three months prior to the site visit scheduled for the week of June 12, 2006 requesting the information listed on the attached letter by April 7, 2006. The attachment listed 32 categories for items to be produced and indicated the specific accounts in the cost report to be audited. Ms. Hess stated that CHS only produced documents responsive to one of the requests. Prior to the site visit a second request was made for the general ledgers.

8. On the last day of the field work, an exit conference was held and signed off by three Clifton Gunderson staff and David McClellan, the Corporate Controller for CHS at the time. The signed form states: "All of

the proposed adjustments *known at this time* were discussed with the Provider and a copy of the proposed adjustments was given to the Provider."

9. At the exit conference after the audit, Clifton Gunderson asked CHS to sign the representation letter, which is part of the Agreed-Upon Procedures. CHS refused to do so.

10. Section 600 of the AICPA requires a representation letter, which is usually signed on the last day of field work. This letter is obtained from the entity being audited, in this case, Respondents.

11. When Clifton Gunderson informed the Department of CHS' refusal to sign the letter, Clifton Gunderson was instructed to proceed with the audit as usual.

12. At the exit conference Clifton Gunderson gave CHS a list of still outstanding documents, which was very similar to the list sent in March 2006. This list included, among other things, invoices, canceled checks and contracts, which would substantiate documentation for reported costs. The letter stated that if the items were not received by Clifton Gunderson by June 30, 2006, Clifton Gunderson would make the required adjustments in its report to the Department. CHS provided some documentation for expenses prior to the deadline and Clifton

Gunderson incorporated that information prior to issuing the proposed cost adjustment letter, which was sent to CHS along with supporting work papers of those adjustments. CHS was given seven days to respond to the report; otherwise, the finalized report would be sent to the Department. CHS did not respond and the draft adjustments were finalized to the Department. The Department received the Audit Input Document, copy of the proposed cost adjustments and papers to support Clifton Gunderson's proposed cost adjustments.

13. After receiving the finalized report from Clifton Gunderson, the Department performed a high level review for accepting the actual audit from Clifton Gunderson to ensure that what had been done was adequately documented in the working papers, and that the adjustments tied back to those working papers that were submitted.

14. The procedures for audits, starting with the RFP, the contractor's work and the Department's process after receiving deliverables from the contract auditor have been the same since 1999. The Agreed-Upon Procedures have been modified periodically since 1999.

15. Clifton Gunderson followed the Agreed-Upon Procedures as prescribed in the RFP and the slight modifications made prior to

commencement of the engagement and conducted a proper audit.

16. A final fiscal audit conference or exit conference may be conducted by the Department's Bureau of Audit "to try and resolve potential findings identified by the Department with the providers." This final fiscal audit conference, which is different than the exit conference held between Clifton Gunderson and CHS immediately after the on-site field work was completed in June 2003, is not mandatory.

17. In this case, Respondents requested final fiscal audit conferences. The Department, however, elected to issue Proposed Adjudication Orders, affording Respondents an opportunity to request a hearing under R.C. Chapter 119.

18. The 2003 cost reports at issue in this matter were used to set the per diem rates for fiscal years 2005 and 2006.

19. The Department audited the patient days and patient liability for: 1) Carington Park, Terrace View Gardens, Vandalia Park, Franklin Ridge, East Galbraith Health Care Center for fiscal years 2003, 2004, 2005, and 2006; 2) Glen Meadows for fiscal years 2004, 2005, and 2006; and 3) Wellington Manor for fiscal years 2005 and 2006.

20. The days audits at issue herein were performed in the same manner as the audit

at issue in *Meadowbrook Care Center v. Ohio Dept. of Job and Family Services* (10th Dist. 2007), 2007-Ohio-6534.

21. After performing the patient day/patient liability audits, ODJFS issued Combined Proposed Adjudication Orders (CPAO) for each open audit period for each of the Respondents. Each CPAO contained Reports of Examination, detailing the "calculation leading to the amount determined to be owed." Respondents each timely requested an exit conference. Thereafter, ODJFS re-issued CPAO's for each facility for each open audit period, providing Respondents the opportunity to request a R.C. Chapter 119 hearing. Each Respondent timely requested a R. C. Chapter 119 administrative hearing.

22. Attachment D attached hereto and incorporated herein reflect the revised patient days and patient liability adjustments. Although Respondent's counsel objected to the adjustments in the Reports of Examination and did not stipulate to the amounts, no evidence was presented to rebut the Department's *prime facie* evidence with respect to patient days and patient liability adjustments. The findings as set forth in Attachment D attached hereto are adopted as a Finding of Fact.

23. Based upon audits on cost reports performed at issue herein, ODJFS issued Notices of Opportunity for Hearing to the facilities for

each of the audits and each Respondent timely filed a request for a R. C. Chapter 119 hearing in the above-referenced matters.

24. Notwithstanding the contents of any initial or any amended Audit Report in these proceedings, the parties have agreed to the Proposed Cost Adjustments set forth in State Exhibit 267a, which is Attachment A, attached hereto and incorporated herein as a Finding of Fact.

25. The parties have stipulated that there were only two issues related to the cost report audit disallowances at issue in this hearing: 1) the Strategic Nursing Services consulting costs (reported by all seven facilities in cost account 6210) and the Providers Choice Administrative Services consulting costs (reported by Carington Park, Terrace View Gardens, Franklin Ridge, Vandalia Park, and East Galbraith Health Care Center in cost account 7215); and 2) the Cincinnati Reds tickets costs reported by Terrace View Gardens, Franklin Ridge, Glen Meadows, and Wellington Manor in cost accounts 6530, 7070, and 7520 and reported by East Galbraith in cost accounts 7070 and 7520.

26. The Proposed Cost Adjustments on State's Exhibit 268 are the sole and only remaining cost report audit adjustment issues. Although the parties agree as to amounts set forth in State Exhibit 268, they disagree as to whether those costs should have been

included in the first place. Stipulations of the Parties, no. 5 These adjustments were made for direct-care consulting costs, found at State Exhibit 268, p. 1, indirect care consulting costs, found at State Exhibit 268, p. 2 and Cincinnati Reds tickets, found at State Exhibit 268, p. 3.

27. Cost reports are the mechanism by which nursing home facilities report their operating costs to the state.

28. Between 1994 and July 1, 2005, Ohio used a prospective cost based payment system, in which a per diem rate was established for each facility based upon the facilities' reasonable costs.

29. Under the Medicare prospective payment system the costs incurred are irrelevant. Reimbursement under the Medicare prospective payment system is dependent upon the type of service performed; the provider is reimbursed a set amount for a set service, regardless of cost.

30. Ohio's prospective cost based system is different than the prospective payment system under Medicare.

31. In 2005, the Ohio legislature passed laws which changed the reimbursement system from the cost-based prospective reimbursement system to a price-based prospective system. During the transition period, the rates in FY 2006 were the same

as those in FY 2005. In FY 2007, the new rates under the price-based prospective system went into effect. Under the price-based prospective system, the State pays "similarly-situated homes the same price subject to case mix adjustments." Rather than looking at the facility's costs, the State looks at "the peer group experience to establish the rate components," while still starting with a calendar year cost report and applying an 18-month inflation factor.

32. CHS– Lake Erie, Inc. d.b.a. Carington Park, provider number 2339268, entered into an agreement with Strategic Nursing Systems, Inc., at State's Exhibit 57. The costs associated with this consulting agreement were reported in account 6210. Strategic Nursing Systems, Inc. invoiced Carington Park monthly for the consulting fees and Carington Park paid each invoice by check as shown in State's Exhibit 58. The consulting agreement (State's Exhibit 57) contained an Attachment A for Enhanced Services, with an additional consulting fee that was due on December 31, 2003, that was invoiced by Strategic Nursing Services as shown by State's Exhibit 59. Carington Park issued an installment promissory note for the December 31, 2003 for the Enhanced Services invoice, State's Exhibit 60. The payments of the installment promissory note were per the note's terms and were by checks at State's Exhibit 61.

33. CHS – Hamilton County, Inc. d.b.a. Terrace View Gardens, provider number 2339384, entered into an agreement with Strategic Nursing Systems, Inc. at State's Exhibit 92. The costs associated with this consulting agreement were reported in account 6210. Strategic Nursing Systems, Inc. invoiced Terrace View Gardens monthly for the consulting fees and Terrace View Gardens paid each invoice by check as shown in State's Exhibit 93. The consulting agreement (State's Exhibit 92) contained an Attachment A for Enhanced Services, with an additional consulting fee that was due on December 31, 2003, that was invoiced by Strategic Nursing Services as shown by State's Exhibit 94. Terrace View Gardens issued an installment promissory note for the December 31, 2003 Enhanced Services invoice, State's Exhibit 95. The payments of the installment promissory note were per the note's terms and were by checks at State's Exhibit 96.

34. CHS - Miami Valley, Inc. d.b.a. Franklin Ridge, provider number 2339688, entered into an agreement with Strategic Nursing Systems, Inc. at State's Exhibit 119. The costs associated with this consulting agreement were reported in account 6210. Strategic Nursing Systems, Inc. invoiced Franklin Ridge monthly for the consulting fees and Franklin Ridge paid each invoice by check as shown in State's Exhibit 120. The consulting agreement (State's Exhibit 119)

contained an Attachment A for Enhanced Services, with an additional consulting fee that was due on December 31, 2003, that was invoiced by Strategic Nursing Services as shown by State's Exhibit 121. Franklin Ridge issued an installment promissory note for the December 31, 2003 Enhanced Services invoice, State's Exhibit 122. The payments of the installment promissory note were per the note's terms and were by checks at State's Exhibit 123.

35. CHS – Miami Valley, Inc. d.b.a. Vandalia Park, provider number 2339624, entered into an agreement with Strategic Nursing Systems, Inc. at State's Exhibit 154. The costs associated with this consulting agreement were reported in account 6210. Strategic Nursing Systems, Inc. invoiced Vandalia Park monthly for the consulting fees and Vandalia Park paid each invoice by check as shown in State's Exhibit 155.

36. CHS – Greater Cincinnati, Inc., d.b.a. East Galbraith Health Care Center, provider number 2399033, entered into an agreement with Strategic Nursing Systems, Inc. at State's Exhibit 181. The costs associated with this consulting agreement were reported in account 6210. Strategic Nursing Systems, Inc. invoiced East Galbraith monthly for the consulting fees and East Galbraith paid each invoice by check as shown in State's Exhibit 182. The consulting agreement (State's

Exhibit 181) contained an Attachment A for Enhanced Services, with an additional consulting fee that was due on December 31, 2003, that was invoiced by Strategic Nursing Services as shown by State's Exhibit 183. East Galbraith issued an installment promissory note for the December 31, 2003 Attachment A Enhanced Services invoice, State's Exhibit 184. The payments of the installment promissory note were per the note's terms and were by checks at State's Exhibit 185. The consulting agreement (State's Exhibit 181) also contained an Attachment B for Enhanced Services, with an additional consulting fee that was due on December 31, 2003, that was invoiced by Strategic Nursing Services as shown by State's Exhibit 186. East Galbraith issued an installment promissory note for the December 31, 2003, Attachment B Enhanced Services invoice, State's Exhibit 187. The payments of the installment promissory note were per the note's terms and were by checks at State's Exhibit 188.

37. CHS - Lake Erie, Inc. d.b.a. Carington Park, provider number 2339268, entered into an agreement with Providers Choice Administrative Services, Inc., at State's Exhibit 63. The costs associated with this consulting agreement were reported in account 7215. Providers Choice Administrative Services, Inc. invoiced Carington Park monthly for the consulting

fees and Carington Park paid each invoice by check as shown in State's Exhibit 64. The consulting agreement (State's Exhibit 63) contained an Attachment A for Enhanced Services, with an additional consulting fee that was due on December 31, 2003. Carington Park issued an installment promissory note for the December 31, 2003 Enhanced Services fee, State's Exhibit 65. The payments of the installment promissory note were per the note's terms and were by checks at State's Exhibit 66.

38. CHS – Hamilton County, Inc. d.b.a. Terrace View Gardens, provider number 2339384, entered into an agreement with Providers Choice Administrative Services, Inc., at State's Exhibit 98. The costs associated with this consulting agreement were reported in account 7215. Providers Choice Administrative Services, Inc. invoiced Terrace View Gardens monthly for the consulting fees and Terrace View Gardens paid each invoice by check as shown in State's Exhibit 99. The consulting agreement (State's Exhibit 98) contained an Attachment A for Enhanced Services, with an additional consulting fee that was due on December 31, 2003. Terrace View Gardens issued an installment promissory note for the December 31, 2003, Enhanced Services fee, at State's Exhibit 100. The payments of the installment promissory note were per the

note's terms and were by checks at State's Exhibit 101.

39. CHS - Miami Valley, Inc. d.b.a. Franklin Ridge, provider number 2339688, entered into an agreement with Providers Choice Administrative Services, Inc., at State's Exhibit 125. The costs associated with this consulting agreement were reported in account 7215. Providers Choice Administrative Services, Inc. invoiced Franklin Ridge monthly for the consulting fees and Franklin Ridge paid each invoice by check as shown in State's Exhibit 126. The consulting agreement (State's Exhibit 125) contained an Attachment A for Enhanced Services, with an additional consulting fee that was due on December 31, 2003. Franklin Ridge issued an installment promissory note for the December 31, 2003, Enhanced Services fee, at State's Exhibit 127. The payments of the installment promissory note were per the note's terms and were by checks at State's Exhibit 128.

40. Miami Valley, Inc. d.b.a. Vandalia Park, provider number 2339624, entered into an agreement with Providers Choice Administrative Services, Inc., at State's Exhibit 157. The costs associated with this consulting agreement were reported in account 7215. Providers Choice Administrative Services, Inc. invoiced Vandalia Park monthly for the consulting

fees and Vandalia Park paid each invoice by check as shown in State's Exhibit 158. The consulting agreement (State's Exhibit 157) contained an Attachment A for Enhanced Services, with an additional consulting fee that was due on December 31, 2003. Vandalia Park issued an installment promissory note for the December 31, 2003, Enhanced Services fee, at State's Exhibit 159. The payments of the installment promissory note were per the note's terms and were by checks at State's Exhibit 160.

41. CHS - Greater Cincinnati, Inc., d.b.a. East Galbraith Health Care Center, provider number 2399033, entered into an agreement with Providers Choice Administrative Services, Inc., at State's Exhibit 190. The costs associated with this consulting agreement were reported in account 7215. Providers Choice Administrative Services, Inc. invoiced East Galbraith monthly for the consulting fees and East Galbraith paid each invoice by check as shown in State's Exhibit 191. The consulting agreement (State's Exhibit 190) contained an Attachment A for Enhanced Services, with an additional consulting fee that was due on December 31, 2003. East Galbraith issued an installment promissory note for the December 31, 2003, Enhanced Services fee, at State's Exhibit 192. The payments of the installment promissory note were per the note's terms and were by checks at State's Exhibit 193.

42. The Annual Services were billed monthly and the invoice specified that payment was due upon receipt. Terrace View Gardens, Franklin Ridge, Vandalia Park, Glen Meadows, and Wellington Manor paid the Strategic Annual Services December 2003 invoices by checks dated March 2005. Carington Park paid the Strategic Annual Services November 2003 invoice by check dated March 2005 and the Strategic Annual Services December 2003 invoice by check dated April 2005.

43. During the cost reporting period at issue herein, Wellington Manor and Glen Meadows had Annual Services contracts with Strategic. Both facilities reported Strategic costs in cost account 6210 on their three-month cost reports covering December 2003 through February 2004.

44. Glen Meadows and Wellington Manor did not produce canceled checks for the Strategic Annual Services January 2004 and February 2004 invoices.

45. Starting in January 2005 and ending in December 2006, East Galbraith Health Care Center paid the Providers Choice Annual Services invoices issued monthly from July 1, 2003 to December 31, 2003.

46. Glen Meadows and Wellington Manor did not provide the auditors with sufficient documentation to support the Strategic

Annual Services costs they reported in the 2003 cost reports.

47. On December 31, 2003, the facilities issued invoices for the Enhanced Services contracts for 2003. The invoices stated: "Payment due upon receipt of invoice."

48. On December 31, 2003, CHS issued installment promissory notes for each of the December 31, 2003 invoices for Enhanced Services.

49. The December 31, 2003, promissory notes that Respondents issued did not require payment to begin until 2005. The parties have stipulated that the Respondents paid the December 31, 2003, promissory notes according to the notes' terms. None of the payments on the promissory notes were made within one year of the end of the relevant cost-reporting periods.

50. A promissory note is a negotiable instrument.

51. All Respondents reported Strategic consulting costs (Annual Services and Enhanced Services) on the 2003 cost reports in cost account 6210. All Respondents reported Providers Choice consulting costs (Annual Services and Enhanced Services) on the 2003 cost reports in cost account 7215.

52. ODJFS' basis for the proposed disallowance of the costs reported in 6210 and 7215 is that

the costs were not timely liquidated as provided by the provisions of 42 CPR §413.100 (Generally described as the "Liquidation of Liabilities Rule") and the provisions of Pub. 15-1 §2305(A), §2305.1 and §2305.2.

53. In the initial release of CHS' audits by the Department there was no application of the Liquidation of Liabilities rule proposed, referenced or cited. Many of the disallowances were based upon insufficient documentation. Upon receipt of documentation, including the invoices, promissory notes and checks involving the Enhanced Services contracts, the Department made disallowances based upon the Liquidation of Liabilities rule.

54. Mr. Fleischer and Mr. Hapchuk stated that the problem with applying the Liquidation of Liabilities rule in this case is that the Ohio legislature changed the law on how the reimbursement rate would be established.

55. Terrace View Gardens, Franklin Ridge, East Galbraith Health Care Center, Glen Meadows and Wellington Manor reported on their 2003 cost reports the costs associated with the purchase of 2004 Cincinnati Reds season tickets. The invoice for these tickets was issued to Joe Tucker. There was no evidence as to who Joe Tucker is and/or what, if any, affiliation he has with CHS. These costs were reported in the "employee

benefits" accounts. No documentation was presented to show how the tickets were distributed or who used the tickets.

Conclusions of Law

To the extent any conclusion of law constitutes a finding of fact, they are offered as such.

1. All statutory procedural requirements have been complied with and this matter is properly before the Department.

2. Medicaid nursing home providers are required to file annual cost reports, which capture the costs and expenses incurred during the year for providing services to residents within the facility. Nursing homes are required to maintain records to support the costs included in the cost reports, including financial, medical and statistical. "In the Medicaid audit setting, a provider must provide supporting documentation that demonstrates that the reported cost was actually incurred, that it is reasonable, allowable and related to patient care." *Meadowwood Nursing Facility v. Ohio Dept. of Job and Family Servs*, (10th Dist. 2005), 2005-Ohio-1263 at ¶19.

3. Pursuant to R.C. 5111.27, the Department is authorized to audit cost reports and the scope of the audit is within the discretion of the Department.

4. If a cost report audit is conducted in such a manner as to produce an accurate result and ther procedures are objectively verifiable, a valid audit is performed. *St. Francis Home Inc. v. Ohio Dept. of Job and Family Services* (10th Dist. 2006) 2006-Ohio-6147.

5. The Department conducted audits of Respondents' 2003 cost reports pursuant to R.C. 5111.27 (eff. 3/30/2006) (renumbered as R.C. 5165.108 effective 9/29/2013) and Ohio Adm. Code 5101:3-3-21 (eff. 7/04/2002), and the Department issued audit reports related to those audits.

6. Clifton Gunderson completed the Agreed-Upon Procedures, which set forth the scope and method to be utilized in conducting the 2003 cost reports audits.

7. Clifton Gunderson completed the engagement, conducted an exit interview with CHS and discussed all the proposed adjustments with CHS, as evidenced by the signature of CHS' Corporate Controller, who signed verifying that fact.

8. The audits, using Agreed-Upon Procedures, which Clifton Gunderson performed on CHS' 2003 cost reports was conducted in such a manner as to produce accurate results and the procedures were objectively verifiable. Therefore, Clifton Gunderson conducted a valid audit.

9. The due process afforded a respondent in an administrative hearing is the right to a reasonable notice of hearing and reasonable opportunity to be heard, including reasonable notice of the subject matter of the hearing. *State ex rel. LTV Steel Co. v. Industrial Comm'n of Ohio* (10th Dist., 1995) 102 Ohio App.3d 100, 103-04. The purpose of the notice requirement in R.C. 119.07 is to enable the respondent to prepare a defense. *Geroc v. Ohio Veterinary Med Bd.* (8th Dist. 1987), 37 Ohio App.3d 192, 198; *Keaton v. Ohio Dept. of Commerce* (10th Dist. 1981), 2 Ohio App.3d 480,482-83

10. Respondents had ample opportunity to prepare a defense on the Liquidation of Liabilities issues, including hiring experts, and suffered no prejudice from the fact that the Notice of Opportunity for Hearing did not include notice of the disallowance under the Liquidation of Liabilities rule.

11. Whether the costs Respondents reported on the 2003 cost reports are allowable was determined pursuant to Ohio Adm. Code 5101:3-3-01 (eff. 9/30/2001) and the laws, regulations, and rules referred to therein.

12. Reported costs are "allowable" if they are "incurred for certified beds in a facility as determined by [the Department] to be reasonable as set forth in [5101:3-3-01(AA)]..." Ohio Adm. Code 5101:3-3-01(A) (eff. 9/30/2001).

13. "'Reasonable' means that a cost is an actual cost that is appropriate and helpful to develop and maintain the operation of patient care facilities and activities, including normal standby costs, and that does not exceed what a prudent buyer pays for a given item or services. Ohio Adm. Code 5101:3-3-01(AA)(eff. 9/30/2001).

14. Pursuant to Ohio Adm. Code 5101:3-3-20(L) (eff. 9/12/2003), Respondents were required to retain current and accurate financial, statistical, and medical records supporting the cost reports or claims for services for six years after all appeal rights relating to the audit reports herein are exhausted. Respondents were also required to make those records available to the Department.

15. A "short-term liability" is a liability due and payable within twelve months. A long-term liability is one due and payable in one year plus one or more days.

16. The Strategic and Providers Choice Annual Services invoices and the Strategic and Providers Choice Enhanced Services invoices were due upon receipt and were therefore short-term liabilities.

17. 42 CFR 213.100 and PRM 2305, which address special treatment of short term liabilities in cost reports when the provider has not expended funds during the current cost reporting period, do not apply in the

prospective payment system used in Medicare.

18. From 1994 through June 30, 2005, Ohio's reimbursement system was based upon reasonable costs and was different than the Medicare prospective payment system.

19. Pursuant to Ohio Admin. Code 5101:3-3-01 (effective 9/30/2001), allowable costs were determined in accordance with a hierarchy of laws and rules as follows: The Ohio Revised Code, then the Ohio Administrative Code, then the Code of Federal Regulations, then the CMS HIM publications or Provider Reimbursement Manual publications and lastly, the general accepted accounting principles (GAAP). Ohio Admin. Code 5101:3-3-01; Ohio Admin. Code 5101:3-3-20.

20. The CFR and PRM are regulations and interpretive guidelines for reportable costs for Medicare cost reports. By including them in the hierarchy of sources to use in determining allowable costs for Medicaid nursing facilities, Ohio adopted these regulations to determine allowable costs for Medicaid cost reports in Ohio. 5101:3-3-0 1(A) There is nothing in the Revised Code or Ohio Administrative Code that states that certain provisions of the CFR or the PRM are not applicable to reporting costs in a cost report. Moreover, there is nothing in the CFR or the PRM that limits the application of any

of the rules included therein to only Medicare or only Medicaid.

21. Pursuant to 42 C.F.R. 413.100(c)(2)(i)(A), to be reported on the relevant 2003 cost reports at issue in this matter, the Strategic and Providers Choice Annual Services and Enhanced Services invoices had to be liquidated within one year after the end of the relevant cost-reporting periods.

22. In addition to the requirement that a short-term liability be liquidated in a year, the PRM CMS 15-1 §2305 places an additional requirement, specifically, where liquidation is made by negotiable instrument, "payment must be redeemed through an actual transfer of the provider's assets" within one year after the end of the cost-reporting period.

23. A promissory note is a negotiable instrument.

24. Pursuant to 42 CFR 413.100 and PRM, CMS Pub. 15-1 §2305, the costs for the Strategic and Providers Choice Enhanced Services December 31, 2003, invoices reported on the 2003 cost reports at issue in this matter, are not allowable costs because the first actual transfer of the CHS assets did not occur until 2005, over one year from the end of the cost reporting period.

25. Pursuant to 42 CFR 413.100 and PRM, CMS Pub. 15-1 §2305, the Strategic Annual Services December 2003 invoice costs

reported by Glen Meadows and Wellington Manor are not allowable costs because the invoices were not liquidated within one year after the end of the relevant cost-reporting periods.

26. Pursuant to Ohio Adm. Code 5101:3-3-20(L) (eff. 9/12/2003) and the Provider Reimbursement Manual ("PRM"), CMS Publication 15-1, § 2305, the Strategic Annual Services January 2004 and February 2004 invoice costs reported by Glen Meadows and Wellington Manor are not allowable costs because the invoices were not liquidated within one year after the end of the relevant cost-reporting periods.

27. Pursuant to 42 CFR 413.100 and PRM, CMS Pub. 15-1 § 2305, the Strategic Annual Services December 2003 invoice costs reported by Terrace View Gardens, Franklin Ridge, Vandalia Park, Glen Meadows, and Wellington Manor are not allowable costs because the invoices were not liquidated within one year after the end of the relevant cost-reporting periods.

28. Pursuant to 42 CFR 413.100 and PRM, CMS Pub. 15-1 § 2305, the Strategic Annual Services November 2003 and December 2003 invoice costs reported by Carington Park are not allowable costs because the invoices were not liquidated within one year after the end of the relevant cost-reporting periods.

29. Pursuant to 42 CFR 413.100 and PRM, CMS Pub. 15-1 § 2305, the Providers Choice Annual Services July 1, 2003, to December 31, 2003, invoice costs reported by East Galbraith Health Care Center are not allowable costs because the invoices were not liquidated within one year after the end of the relevant cost-reporting periods.

30. The adjustments on State's Exhibit 268 are correct.

31. Pursuant to the parties' stipulations, the adjustments on State's Exhibit 267a are correct.

32. PRM 2105.8 specifically prohibits the reimbursement of sporting events.

33. PRM 2105.8 allows reasonable costs "incurred by providers for purposes of employee morale, specifically, for annual employee Christmas or holiday party, an annual employee award ceremony or for sponsorship of employee athletic programs (bowling, softball, basketball teams, etc.)"

34. The 2004 Cincinnati Reds season tickets are a prohibited expense, are not one of, or similar to one of, the listed employee morale examples, and were not conferred during the 2003 cost reporting period. There was no evidence who actually received these tickets. Accordingly, the cost for the 2004 Cincinnati Reds tickets are not allowable costs.

35. Any audit report, report of examination, exit conference report or report of final settlement issued by ODJFS and entered into evidence is to be considered prima facie evidence of what it asserts. Ohio Admin. Code 5101:6-50-09(A)(4).

36. The following patient days/patient liability adjustments are correct:

Facility	**Patient Days/ Patient Liability FY Audit at Issue**	**Adjust-ments to Patient Liability**	**Adjust-ments to No. of Paid Patient Days**
Carington Park	FY 2003	$8,892.76	363.5
Carington Park	FY 2004	$5844.28	167
Carington Park	FY 2005	$2,849.76	337
Carington Park	FY 2006	$10,191.70	374.5
Terrace View Gardens	FY 2003	$6,461.32	296.50
Terrace View Gardens	FY 2004	$910.00	51

Terrace View Gardens	FY 2005	$945.00	19
Terrace View Gardens	FY 2006	-$3,706.00	3.0
Vandalia Park	FY 2003	$8378.65	592.5
Vandalia Park	FY 2004	$0	198
Vandalia Park	FY 2005	$528.42	161.5
Vandalia Park	FY 2006	-$2990.20	441
Franklin Ridge	FY 2003	$1,404.98	175
Franklin Ridge	FY 2004	$2,385.00	93
Franklin Ridge	FY 2005	$1,474.88	61.5
Franklin Ridge	FY 2006	-$1.563.00	7
East Galbraith	FY 2003	$0.00	3
East Galbraith	FY 2004	$405.00	54.5

East Galbraith	FY 2005	$0.00	45
East Galbraith	FY 2006	$2827.64	867
Welling-ton Manor	FY 2005	$0.00	3.5
Wellington Manor	FY 2006	-$18.00	2.5
Glen Meadows	FY 2004	$994.62	11.5
Glen Meadows	FY 2005	$0.00	16
Glen Meadows	FY 2006	-$6,385.00	9

37. Based upon the foregoing findings of fact and conclusions of law, and incorporating the adjustments on State's Exhibits 267a and 268 and on the preceding patient days/patient liability chart, Respondents owe the Department the following amounts for each fiscal year:

Facility	**Audit Issues**	**Amount Owed by CHS**
Carington Park	FY 2003 Patient days/patient liability audit only	$43,509.40

Carington Park	FY 2004 Patient days/ patient liability audit only	$25,067.70
Carington Park	FY 2005 CY 2003 cost report audit and FY 2005 patient days/patient liability audit	$2,586,852.40
Carington Park	FY 2006 CY 2003 cost report audit and FY 2006 patient days/patient liability audit	$2,608,779.73
Terrace View Gardens	FY 2003 Patient days/patient liability audit	$47,821.90
Terrace View Gardens	FY 2004 Patient days/ patient liability audit only	$10,022.77
Terrace View Gardens	FY 2005 CY 2003 cost report audit and FY 2005 patient days/patient liability audit	$564,212.69
Terrace View Gardens	FY 2006 CY 2003 cost report audit and FY 2006 patient days/patient liability audit	$537,237.84

Vandalia Park	FY 2003 Patient days/patient liability audit only	$88,945.40
Vandalia Park	FY 2004 Patient days/ patient liability audit only	$35,340.11
Vandalia Park	FY 2005 CY 2003 cost report audit and FY 2005 patient days/patient liability audit	$270,681.51
Vandalia Park	FY 2006 CY 2003 cost report audit and FY 2006 patient days/patient liability audit	$230,730.54
Franklin Ridge	FY 2003 Patient days/patient liability audit only	$29,858.76
Franklin Ridge	FY 2004 Patient days/ patient liability audit only	$16,407.45
Franklin Ridge	FY 2005 CY 2003 cost report audit and FY 2005 patient days/patient liability audit	$584,324.18

Franklin Ridge	FY 2006 CY 2003 cost report audit and FY 2006 patient days/patient liability audit	$577,418.87
East Galbraith	FY 2003 Patient days/patient liability audit only	$606.54
East Galbraith	FY 2004 Patient days/ patient liability audit only	$30,997.09
East Galbraith	FY 2005 CY 2003 cost report audit and FY 2005 patient days/patient liability audit	$913,384.29
East Galbraith	FY 2006 CY 2003 cost report audit and FY 2006 patient days/patient liability audit	$1,215,526.66
Welling-ton Manor	FY 2005 CY 2003 cost report audit and FY 2005 patient days/patient liability audit	$213,205.07

Wellington Manor	FY 2006 CY 2003 cost report audit and FY 2006 patient days/patient liability audit	$218,261.37
Glen Meadows	FY 2004 Patient days/ patient liability audit only	$1,317.80
Glen Meadows	FY 2005 CY 2003 cost report audit and FY 2005 patient days/patient liability audit	$121,990.35
Glen Meadows	FY 2006 CY 2003 cost report audit and FY 2006 patient days/patient liability audit	$139,057.54

Total: $11,111,557.96

Recommendation

Based upon the foregoing Findings of Fact and Conclusions of Law, it is recommended that ODM adopt the patient days/patient liabilities adjustments as set forth in Attachment D, (attached hereto and incorporated herein), the adjustments in State Exhibit 267a (attached hereto as Attachment A and incorporated herein), and the adjustments in State Exhibit 268 (attached hereto as Attachment B and incorporated herein). It is further recommended that it

be ordered that Respondents owe the Department of Medicaid the amounts set forth in Conclusion of Law No. 37. This recommendation is not a final order, and may be approved, modified or rejected by the Director of the Ohio Department of Medicaid, and shall not become a final order unless and until it is approved by the Director.

10-31-2015
Date

/s/Mary K. Crawford
Mary K. Crawford
Hearing Examiner
P.O. Box 14366
Columbus, Ohio 43214

CERTIFICATE OF SERVICE

I certify that the original of this document was hand delivered to the Ohio Department of Medicaid, Office of Legal Counsel, 50 W. Town Street, Columbus Ohio, on November 2, 2015, with instruction that file-stamped copies are to be delivered by Department personnel to the parties and their attorneys of record, if any, in the manner prescribed by law and at the addresses shown in the record of these proceedings.

/s/ Mary K. Crawford
Mary K. Crawford

Stipulated Audit Adjustment Amounts for CHS-Lake Erie, Inc. d.b.a. Carington Park, Prov.# 2339260			
COST ACCOUNT NUMBER	**ADJUST-MENT NUMBER**	**ORIGI-NAL ADJUST-MENT INC./ (DEC.)**	**STIPU-LATED ADJUST-MENT AMOUNT**
6001	1	(3,994)	0
6006	1	(1,242)	0
6001	2	(5,642)	(5,642)
6001	3	(45)	(45)
6020	3	(17,641)	0
6001	4	(1,970)	0
6001	5	(1,573)	(1,573)
6006	5	(1,710)	(1,710)
7055	5	54	54
7350	5	3,229	3,229
6001	6	(131)	(131)
6170	8	(25,480)	(25,480)
6530	8	(222,840)	0
7280	9	(129,723)	0

7340	9	(5,545)	0
7340	11	(960)	(960)
8030	11	192	192
E-1	11	960	960
E-1	11	(192)	(192)
8020	12	(1,056)	(1,056)
8030	12	(19,776)	0
8040	12	(65,218)	0
E-1	12	(440,231)	0
E-1	12	177,233	0
E-1	12	(440,231)	0
E-1	12	263,283	0
8020	13	(148)	0
8030	13	(3,205)	0
8065	14	(119,016)	0
8195	15	(1,094,692)	0
8070	16	(11,372)	0
6095	17	(2,904)	0
6230	17	(30,461)	0
7310	17	(653,370)	(4,494)
8090	17	(17,463)	0

Stipulated Audit Adjustment Amounts for CHS-Ohio Valley, Inc. d.b.a Terrace View Gardens, Prov # 2339384			
COST ACCOUNT NUMBER	**ADJUST-MENT NUMBER**	**ORIGI-NAL ADJUST-MENT INC./ (DEC.)**	**STIPU-LATED ADJUST-MENT AMOUNT**
6001	1	(2,666)	(2,625)
6001	2	(1,863)	(1,863)
7025	2	301	301
7120	2	16	16
7350	2	1,546	1,546
6530	3	(128,569)	0
7340	5	(3,431)	0
7340	6	(1,085)	(1,085)
8040	6	164	164
E-1	6	1,085	1,085
E-1	6	(164)	(164)
8020	8	(1,404)	0
8030	8	(1,423)	0
8040	8	(2,617)	0

E-1	8	(52,501)	0
E-1	8	17,052	0
E-1	8	(52,501)	0
E-1	8	22,497	0
8030	9	(167)	0
8040	9	(49)	0
8065	10	(49,682)	0
8195	11	(538,740)	0
A-1	12	4	4
6095	14	(1,175)	0
6230	14	(12,324)	0
7310	14	(141,347)	(1,818)
8090	14	(8,510)	(1,445)
6520	15	(28,002)	0
7065	15	(3,292)	0
7510	15	(4,477)	0

Stipulated Audit Adjustment Amounts for CHS-Miami Valley, Inc. d.b.a Franklin Ridge, Prov # 2339688			
COST ACCOUNT NUMBER	**ADJUST-MENT NUMBER**	**ORIGI-NAL ADJUST-MENT INC./ (DEC.)**	**STIPU-LATED ADJUST-MENT AMOUNT**
6000	1	(2,064)	(2,064)
6001	1	(168)	(168)
6006	1	(1,300)	(1,300)
7025	1	252	252
7055	1	117	117
7220	1	51	51
7320	1	3,112	3,112
6001	2	(1,452)	0
6001	3	(1,559)	(1,559)
6470	4	(1,700)	0
6530	4	(130,622)	0
7280	6	(64,380)	0
7340	6	(4,506)	(399)
7340	7	(1,734)	(1,734)

7340	8	(2,110)	(2,110)
8065	8	2,110	2,110
8030	9	(4,996)	0
8040	9	(6,738)	0
E-1	9	(58,671)	0
E-1	9	27,987	0
E-1	9	(58,671)	0
E-1	9	39,721	0
8040	10	(1,007)	0
E-1	10	(5,035)	0
E-1	10	671	0
E-1	10	(5,035)	0
E-1	10	1,678	0
8030	11	(7,290)	0
8040	11	(18,768)	0
8065	12	(97,186)	0
8195	13	(242,625)	0
8070	14	(11,579)	0
A-1	15	10	10
6095	17	(1,352)	0
6230	17	(14,186)	0

7310	17	(122,743)	(2,093)
8090	17	(8,133)	0
7200	18	(943)	0

Stipulated Audit Adjustment Amounts for CHS-Miami Valley, Inc. d.b.a Vandalia Park, Prov # 2339624			
COST ACCOUNT NUMBER	**ADJUST-MENT NUMBER**	**ORIGI-NAL ADJUST-MENT INC./ (DEC.)**	**STIPU-LATED ADJUST-MENT AMOUNT**
6001	1	(4,959)	(4,959)
6530	1	1,912	1,912
7520	1	420	420
7350	1	2,627	2,627
6001	2	(25,817)	0
6006	2	(1,965)	0
6001	3	(136)	(136)
6001	4	(5,327)	(5,327)
6530	6	(142,376)	(5,225)
7340	7	(8,586)	0
7340	8	(679)	(679)
8020	9	(2,060)	0
8030	9	(13,740)	0
8040	9	(41,734)	0

E-1	9	(287,672)	0
E-1	9	98,759	0
E-1	9	(287,672)	0
E-1	9	142,723	0
8040	10	(8,047)	0
8065	11	(202,325)	0
8195	12	(392,600)	0
8070	13	(15,432)	0
6095	14	(2,277)	0
6230	14	(23,886)	0
7310	14	(242,197)	(3,524)
8090	14	(13,694)	0
7200	15	(757)	0

Stipulated Audit Adjustment Amounts for CHS-Greater Cincinnati, Inc. d.b.a East Galbraith Health Care Center, Prov # 2399033			
COST ACCOUNT NUMBER	**ADJUST-MENT NUMBER**	**ORIGI-NAL ADJUST-MENT INC./ (DEC.)**	**STIPU-LATED ADJUST-MENT AMOUNT**
E-1	1	(159,259)	0
6001	2	(2,875)	(2,875)
6001	3	(3,743)	(3,743)
6006	3	(69)	(69)
7350	3	3,351	3,351
8065	3	461	461
6190	5	(50,705)	0
6530	5	(131,626)	0
7350	6	(3,685)	0
7340	7	(2,537)	(2,537)
8065	8	(43,924)	(6,493)
8195	9	(286,529)	0
6095	11	(792)	0
6230	11	(8,311)	0

7310	11	(83,774)	(1,226)
8090	11	(5,628)	(863)
7200	13	(1,568)	0

Stipulated Audit Adjustment Amounts for CHS-Glenwell, Inc. d.b.a Glen Meadows Prov # 2429330			
COST ACCOUNT NUMBER	**ADJUST-MENT NUMBER**	**ORIGI-NAL ADJUST-MENT INC./ (DEC.)**	**STIPU-LATED ADJUST-MENT AMOUNT**
7070	1	(3,580)	0
7060	1	(220)	0
7220	1	(306)	(306)
7500	1	(1,007)	0
7520	1	(5,990)	0
E-1	1	(172,100)	(172,100)
E-1	1	(517)	(517)
7125	2	(2,414)	(2,414)
6001	3	(7,164)	0
6030	3	(6,029)	0
6001	4	(76)	(76)
6001	5	(270)	(270)
6001	6	(845)	(845)
7025	6	58	58

7120	6	92	92
7220	6	323	323
7350	6	372	372
6530	7	(33,290)	0
6550	7	(5,865)	(4,740)
6530	9	(25,149)	0
6530	10	(30,018)	0
7225	11	(4,652)	0
7265	11	(1,110)	0
7280	11	(19,984)	0
7290	11	(2,099)	0
7340	11	(6,451)	0
7265	12	(2,767)	0
7215	13	(14,071)	0
7340	13	(1,371)	(1,371)
E-1	14	(64,300)	(64,300)
8030	15	(1,607)	0
8040	15	(5,187)	0
8050	15	(1,100)	0
E-1	15	(153,863)	0
E-1	15	95,651	0

8030	16	(654)	0
8040	16	(97)	0
8065	17	(26,081)	0
8195	18	(136,188)	0
A-1	19	8	8
6095	21	(376)	0
6230	21	(3,038)	0
7310	21	(29,064)	(396)
8090	21	(1,529)	0
7200	22	(1,140)	0
E-1	23	(566,294)	(566,294)
E-1	24	(66,274)	(66,274)
6120	25	(1,489)	0
6195	25	(7,176)	0

Stipulated Audit Adjustment Amounts for CHS-Glenwell, Inc. d.b.a Wellington Manor of Butler County. Prov # 2429321			
COST ACCOUNT NUMBER	**ADJUST-MENT NUMBER**	**ORIGI-NAL ADJUST-MENT INC./ (DEC.)**	**STIPU-LATED ADJUST-MENT AMOUNT**
7070	1	(8,048)	0
E-1	1	(274,400)	(274,400)
7125	2	(2,027)	(2,027)
E-1	3	(29,400)	(29,400)
6001	4	(2,152)	0
6006	4	(101)	0
6001	5	(145)	(145)
6006	5	(325)	(325)
7025	5	97	97
7120	5	31	31
7255	5	17	17
7350	5	325	325
6060	6	(1,718)	0
6001	7	(30,000)	(30,000)

6100	9	(2,050)	0
6530	9	(48,681)	0
6530	10	(15,859)	0
7280	11	(18,038)	0
7340	11	(4,854)	0
7520	11	(7,439)	0
7215	12	(10,909)	0
8020	13	(638)	0
8030	13	(1,160)	0
8040	13	(2,194)	0
E-1	13	(90,870)	0
E-1	13	66,268	0
8020	14	(218)	0
8030	14	(668)	0
8040	14	(513)	0
8065	15	(20,103)	0
8195	16	(115,248)	0
6095	18	(281)	0
6230	18	(2,274)	0
7310	18	(21,758)	(296)
8090	18	(1,145)	0

6520	19	(4,648)	0
7065	19	(463)	0
7510	19	(750)	0
E-1	20	(112,536)	(112,536)
E-1	21	(60,470)	(60,470)
6120	22	(2,156)	0

STIPULATED DISPUTED AMOUNT - COST ACCOUNT 6210			
NAME & PROVIDER NO.	ADJUST-MENT NO.	ORIGINAL ADJUST-MENT NO.	STIPU-LATED DISPUTED AMOUNT
CARRING-TON PARK, 2339268	7	(2,395,856)	(2,128,476)
TERRACE VIEW GARDENS, 2339384	4	(727,104)	(610,592)
FRANKLIN RIDGE, 2339688	4 5	(425,00) (153,456)	(284,332) (153,456)
VANDALIA PARK, 2339624	5	(249,552)	(20,796)
EAST GAL-BRAITH HEALTH CARE CENTER, 2399033	4	(555,550)	(430,000)
GLEN MEADOWS, 2429330	8	(39,655)	(39,655)

WELLING-TON MANOR OF BUTLER COUNTY, 2429321	8	(30,741)	(30,741)

After discovering that the Provider No. for Franklin Ridge was incorrect on State Exhibit 268, during the hearing, the parties agreed that the correct number could be inserted in pen on the exhibit. (Tr., Pt. II, pp. 20-21)

STIPULATED DISPUTED AMOUNT - COST ACCOUNT 7215			
NAME & PROVIDER NO.	ADJUST-MENT NO.	ORIGINAL ADJUST-MENT NO.	STIPU-LATED DISPUTED AMOUNT
CARRING-TON PARK, 2339268	9	(625,000)	(520,632)
	10	(44,368)	(44,368)
TERRACE VIEW GARDENS, 2339384	5	(200,000)	(152,251)
	7	(17,749)	(17,749)
FRANKLIN RIDGE, 2339688	6	(200,000)	(200,000)
	7	(54,456)	0
VANDALIA PARK, 2339624	7	(350,000)	(251,379)
	8	(73,621)	(73,621)
EAST GAL-BRAITH HEALTH CARE CENTER, 2399033	6	(350,000)	(350,000)
	7	(15,000)	(15,000)

STIPULATED DISPUTED AMOUNT - REDS TICKETS ISSUE			
NAME & PROVIDER NO.	ADJUST-MENT NO.	ORIGINAL ADJUST-MENT NO.	STIPU-LATED DISPUTED AMOUNT
TERRACE VIEW GARDENS, 2339384	6530 7070 7520	13 13 13	(907) (113) (114)
FRANKLIN RIDGE, 2339688	6530 7070 7520	16 16 16	(907) (113) (114)
EAST GAL-BRAITH, 2399033	7070 7520	10 10	(113) (114)
GLEN MEADOWS, 2429330	6530 7070 7520	20 20 20	(907) (113) (114)

WELLING-TON MANOR 2429321	6530	17	(907)
	7070	17	(113)
	7520	17	(114)

BEFORE THE OHIO DEPARTMENT OF JOB AND FAMILY SERVICES

In the Matters of:

CHS-Glenwell, Inc. 09 LTC17
CHS-Glenwell, Inc. 09LTC18
CHS-Glenwell, Inc. 09LTC119

CHS-Hamilton County, Inc. 09LTC30
CHS-Hamilton County, Inc. 09L TC31
CHS-Hamilton County, Inc. 09LTC32
CHS-Hamilton County, Inc. 09LTC33

Carington Health Systems 09LTC24
Carington Health Systems 09LTC25

CHS-Miami Valley, Inc. 09LTC13
CHS-Miami Valley, Inc. 09LTC14
CHS-Miami Valley, Inc. 09LTC15
CHS-Miami Valley, Inc. 09LTC16

CHS-Miami Valley, Inc. 09LTC34
CHS-Miami Valley, Inc. 09LTC35
CHS-Miami Valley, Inc. 09LTC36
CHS-Miami Valley, Inc. 09LTC37

CHS-Greater Cincinnati, Inc. 09LTC20
CHS-Greater Cincinnati, Inc. 09LTC21
CHS-Greater Cincinnati, Inc. 09LTC22
CHS-Greater Cincinnati, Inc. 09LTC23

CHS-Lake Erie, Inc. 09LTC26
CHS-Lake Erie, Inc. 09L TC27

CHS-Lake Erie, Inc. 09LTC28
CHS-Lake Erie, Inc. 09LTC29,

Respondents/Providers.

Mary K. Crawford
Hearing Examiner

STIPULATIONS OF THE PARTIES

The Department of Job and Family Services and the Respondents (hereinafter collectively "Carington Health Systems") stipulate and agree that for all purposes in these adjudicatory hearings, and any appeals arising, therefrom that the following stipulations are made, entered into and binding upon the parties as evidenced by the signatures of their counsel, as facts which do not require testimony or other evidence.

It is therefore stipulated by the parties that:

1. Carington Health Systems timely filed a request for adjudicatory hearing in the referenced matters.

2. Carington Health Systems does not, by entering into this stipulation, waive its right to contest on procedural and/or substantive grounds the DJFS's position on and relating to the issue regarding "Liquidation of Liabilities".

3. Carington Health Systems does not waive any objections to the Audit Reports and Reports of Final Settlement previously addressed in this matter by hearing before the Hearing Examiner consisting principally of whether the Department of Job and Family Services ("DJFS") conducted an audit in

compliance with the Ohio Revised Code and Ohio Administrative Codes governing provisions.

4. Notwithstanding the contents of any initial or any amended Audit Report in these proceedings, the parties have agreed to the Proposed Cost Adjustments on State's Exhibits 267.

5. The Proposed Cost Adjustments on State's Exhibit 268 are the sole and only remaining cost report audit adjustment issues (excepting the findings for resident days remain an issue for each of the Carington Health Systems' facilities):

6. With respect to account 6210 on State's Exhibit 268, it is stipulated that:

> **A**. CHS – Lake Erie, Inc. d.b.a. Carington Park, provider number 2339268, entered into an agreement with Strategic Nursing Systems, Inc, at State's Exhibit 57. The costs associated with this consulting agreement were reported in account 6210. Strategic Nursing Systems, Inc. invoiced Carington Park monthly for the consulting fees and Carington Park paid each invoice by check as shown in State's Exhibit 58. The consulting agreement (State's Exhibit 57) contained an Attachment A for Enhanced Services, with an additional consulting fee that was due on December 31, 2003, that was invoiced by Strategic Nursing Services as shown by State's Exhibit 59. Carington Park issued an installment promissory note for the December 31, 2003 for the Enhanced Services invoice, State's Exhibit 60. The payments of the

installment promissory note were per the note's terms and were by checks at State's Exhibit 61.

B. CHS – Hamilton County, Inc. d.b.a. Terrace View Gardens, provider number 2339384, entered into an agreement with Strategic Nursing Systems, Inc. at State's Exhibit 92. The costs associated with this consulting agreement were reported in account 6210. Strategic Nursing Systems, Inc. involced Terrace View Gardens monthly for the consulting fees and Terrace View Gardens paid each invoice by check as shown in State's Exhibit 93. The consulting agreement (State's Exhibit 92) contained an Attachment A for Enhanced Services, with an additional consulting fee that was due on December 31, 2003, that was invoiced by Strategic Nursing Services as shown by State's Exhibit 94. Terrace View Gardens issued an installment promissory note for the December 31, 2003 Enhanced Services invoice, State's Exhibit 95. The payments of the installment promissory note were per the note's terms and were by checks at State's Exhibit 96.

C. CHS – Miami Valley, Inc. d.b.a. Franklin Ridge, provider number 2339688, entered into an agreement with Strategic Nursing Systems, Inc. at State's Exhibit 119. The costs associated with this consulting agreement were reported in account 6210. Strategic Nursing Systems, Inc. invoiced Franklin Ridge monthly for the consulting fees and Franklin Ridge paid each invoice by check as shown in State's Exhibit 120.

The consulting agreement (State's Exhibit 119) contained an Attachment A for Enhanced Services, with an additional consulting fee that was due on December 31, 2003, that was invoiced by Strategic Nursing Services as shown by State's Exhibit 121. Franklin Ridge issued an installment promissory note for the December 31, 2003 Enhanced Services invoice, State's Exhibit 122. The payments of the installment promissory note were per the note's terms and were by checks at State's Exhibit 123.

D. CHS – Miami Valley, Inc. d.b.a. Vandalia Park, provider number 2339624, entered into an agreement with Strategic Nursing Systems, Inc. at State's Exhibit 154. The costs associated with this consulting agreement were reported in account 6210. Strategic Nursing Systems, Inc. invoiced Vandalia Park monthly for the consulting fees and Vandalia Park paid each invoice by check as shown in State's Exhibit 155.

E. CHS-Greater Cincinnati, Inc., d.b.a. East Galbraith Health Care Center, provider number 2399033, entered into an agreement with Strategic Nursing Systems, Inc. at State's Exhibit 181. The costs associated with this consulting agreement were reported in account 6210. Strategic Nursing Systems, Inc. invoiced East Galbraith monthly for the consulting fees and East Galbraith paid each invoice by check as shown in State's Exhibit 182. The consulting agreement (State's Exhibit 181) contained an Attachment A for Enhanced Services, with an

additional consulting fee that was due on December 31, 2003, that was invoiced by Strategic Nursing Services as shown by State's Exhibit 183. East Galbraith issued an installment promissory note for the December 31, 2003 Attaclunent A Enhanced Services invoice, State's Exhibit 184. The payments of the installment promissory note were per the note's terms and were by checks at State's Exhibit 185. The consulting agreement (State's Exhibit 181) also contained an Attachment B for Enhanced Services, with an additional consulting fee that was due on December 31, 2003, that was invoiced by Strategic Nursing Services as shown by State's Exhibit 186. East Galbraith issued an installment promissory note for the December 31, 2003, Attachment B Enhanced Services invoice, State's Exhibit 187. The payments of the installment promissory note were per the note's terms and were by checks at State's Exhibit 188.

7. With respect to account 7215 on State's Exhibit 268, it is stipulated that:

A. CHS – Lake Erie, Inc. d.b.a. Carington Park, provider number 2339268, entered into an agreement with Providers Choice Administrative Services, Inc, at State's Exhibit 63. The costs associated with this consulting agreement were reported in account 7215. Providers Choice Administrative Services, Inc. invoiced Carington Park monthly for the consulting fees and Carington Park paid each invoice by check as shown in State's Exhibit 64.

The consulting agreement (State's Exhibit 63) contained an Attachment A for Enhanced Services, with an additional consulting fee that was due on December 31, 2003. Carington Park issued an installment promissory note for the December 31, 2003 Enhanced Services fee, State's Exhibit 65. The payments of the installment promissory note were per the note's terms and were by checks at State's Exhibit 66.

B. CHS – Hamilton County, Inc. d.b.a. Terrace View Gardens, provider number 2339384, entered into an agreement with Providers Choice Administrative Services, Inc, at State's Exhibit 98. The costs associated with this consulting agreement were reported in account 7215. Providers Choice Administrative Services, Inc. invoiced Terrace View Gardens monthly for the consulting fees and Terrace View Gardens paid each invoice by check as shown in State's Exhibit 99. The consulting agreement (State's Exhibit 98) contained an Attachment A for Enhanced Services, with an additional consulting fee that was due on December 31, 2003. Terrace View Gardens issued an installment promissory note for the December 31, 2003, Enhanced Services fee, at State's Exhibit 100. The payments of the installment promissory note were per the note's terms and were by checks at State's Exhibit 101.

C. CHS – Miami Valley, Inc. d.b.a. Franklin Ridge, provider number 2339688, entered into an agreement with Providers Choice

Administrative Services, Inc., at State's Exhibit 125. The costs associated with this consulting agreement were reported in account 7215. Providers Choice Administrative Services, Inc. invoiced Franklin Ridge monthly for the consulting fees and Franklin Ridge paid each invoice by check as shown in State's Exhibit 126. The consulting agreement (State's Exhibit 125) contained an Attachment A for Enhanced Services, with an additional consulting fee that was due on December 31, 2003. Franklin Ridge issued an installment promissory note for the December 31, 2003, Enhanced Services fee, at State's Exhibit 127. The payments of the installment promissory note were per the note's terms and were by checks at State's Exhibit 128.

D. CHS – Miami Valley, Inc. d.b.a. Vandalia Park, provider number 2339624, entered into an agreement with Providers Choice Administrative Services, Inc., at State's Exhibit 157. The costs associated with this consulting agreement were reported in account 7215. Providers Choice Administrative Services, Inc. invoiced Vandalia Park monthly for the consulting fees and Vandalia Park paid each invoice by check as shown in State's Exhibit 158. The consulting agreement (State's Exhibit 157) contained an Attachment A for Enhanced Services, with an additional consulting fee that was due on December 31, 2003. Vandalia Park issued an installment promissory note for the December 31, 2003, Enhanced Services fee, at State's Exhibit 159. The payments of the

installment promissory note were per the note's terms and were by checks at State's Exhibit 160.

E. CHS-Greater Cincinnati, Inc., d.b.a. East Galbraith Health Care Center, provider number 2399033, entered into an agreement with Providers Choice Administrative Services, Inc., at State's Exhibit 190. The costs associated with this consulting agreement were reported in account 7215. Providers Choice Administrative Services, Inc. invoiced East Galbraith monthly for the consulting fees and East Galbraith paid each invoice by check as shown in State's Exhibit 191. The consulting agreement (State's Exhibit 190) contained an Attachment A for Enhanced Services, with an additional consulting fee that was due on December 31, 2003. East Galbraith issued an installment promissory note for the December 31, 2003, Enhanced Services fee, at State's Exhibit 192. The payments of the installment promissory note were per the note's terms and were by checks at State's Exhibit 193.

8. Based upon documents received during the discovery process, DJFS will not proceed on disallowance of costs in accounts 6210 and 7215 on the basis of related party. DJFS will not proceed for disallowance of costs in accounts 6210 and 7215 for inadequate documentation as to Terrace View, Vandalia Park, East Galbraith Health Care Center, Carington Park and Franklin Ridge. As to Wellington Manor and Glen Meadows the record will be held open on the issue of inadequate documentation pending

receipt of cancelled checks and invoices for January and February, 2004, for Account 6210. The DJFS's basis for the proposed disallowance of the costs reported in 6210 and 7215 is that the costs were not timely liquidated as provided by the provisions of 42 CFR §413.100 (Generally described as the "Liquidation of Liabilities Rule") and the provisions of Pub. 15-1 §2305(A), §2305.1 and §2305.2.

9. Each party's exhibits are admitted for all relevant purposes.

10. The evidence presented at the Phase I hearing regarding the issue of whether an audit was conducted applies to all seven providers.

IT IS SO AGREED;

/s/William Greene, Esq.
William Greene, Esq.
Charity Rohl, Esq.
Assistant Attorneys General
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Counsel for CHS

Facility	**Patient Days/ Patient Liability FY Audit at Issue**	**State's Exhibit No.**	**Adjust-ments to Patient Liability**[1]	**Adjust-ments to No. of Paid Patient Days**
Caring-ton Park	FY 2003	242	$8,892.76 p. 19 (column C)	363.5 p. 8 (column E)
Carington Park	FY 2004	243	$5844.28 p. 20 (column C)	167 p. 8 (column E)
Carington Park	FY 2005	244a	$2,849.76 p. 21 (column C)	337 p. 5 (column E)

[1] The patient-liability adjustment amounts in this chart are not the amounts that CHS owes to ODM. The total amounts the CHS facilities owe to ODM are calculated by multiplying the correct number of patient days by the correct rate and subtracting the correct patient liability.

Carington Park	FY 2006	245b	$10,191.70 p. 19 (column C)	374.5 p. 5 (column E)
Terrace View Gardens	FY 2003	246	$6,461.32 p. 15 (column C)	296.50 p. 5 (column E)
Terrace View Gardens	FY 2004	247	$910.00 p. 10 (column C)	51 p. 6 (column E)
Terrace View Gardens	FY 2005	248	$945.00 p. 14 (column C)	19 p. 5 (column E)
Terrace View Gardens	FY 2006	249a	-$3,706. 00 p. 10 (column C)	3.0 p. 5 (column E)
Vandalia Park	FY 2003	250	$8378.65 p. 17 (column C)	592.5 p. 6 (column C)

Vandalia Park	FY 2004	251	$0 p. 17 (column C)	198 p. 6 (column E)
Vandalia Park	FY 2005	252a	$528.42 p. 16 (column C)	161.5 p. 5 (column E)
Vandalia Park	FY 2006	253a	-$2990.20 p. 19 (column C)	441 p. 5 (column E)
Franklin Ridge	FY 2003	254	$1,404.98 p. 17 (column C)	175 p. 6 (column E)
Franklin Ridge	FY 2004	255	$2,385.00 p. 14 (column C)	93 p. 6 (column E)
Franklin Ridge	FY 2005	256a	$1,474.88 p. 15 (column C)	61.5 P. 5 (column E)

Franklin Ridge	FY 2006	257a	-$1.563.00 p. 9 (column C)	7 p. 5 (column E)
East Galbraith	FY 2003	258	$0.00 p. 9 (column C)	3 p. 6 (column E)
East Galbraith	FY 2004	259	$405.00 p. 12 (column C)	54.5 P. 6 (column E)
East Galbraith	FY 2005	260a	$0.00 p. 32 (column C)	45 p. 21 (column E)
East Galbraith	FY 2006	261a	$2827.64 p. 19 (column C)	867 p. 5 (column E)
Welling-ton Manor	FY 2005	262	$0.00 p. 10 (column C)	3.5 p. 5 (column E)

Wellington Manor	FY 2006	263	-$18.00 p. 10 (column C)	2.5 p. 5 (column E)
Glen Meadows	FY 2004	264	$994.62 p. 12 (column C)	11.5 p. 6 (column E)
Glen Meadows	FY 2005	265a	$0.00 p. 12 (column C)	16 p. 6 (column E)
Glen Meadows	FY 2006	266a	-$6,385.00 p. 8 (column C)	9 p. 5 (column E)

APPENDIX G

OHIO DEPARTMENT OF MEDICAID
50 W. TOWN STREET
COLUMBUS, OHIO

[Filed: October 31, 2015]

IN THE MATTER OF:

CHS-Glenwell, Inc. 09LTC17-19
CHS-Ohio Valley, Inc. 09LTC30-33
CHS-Glenwell, Inc. 09LTC24-25
CHS-Miami Valley, Inc. 09LTCl3-16, 34-37
CHS-Greater Cincinnati, Inc. 09LTC20-23
CHS-Lake Erie, Inc. 09LTC26-29

Mary K. Crawford
Hearing Examiner

Respondents/Providers

October 31, 2015

Report and Recommendation

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Nature of the Case

These are proceedings taken pursuant to Ohio Revised Code Chapters 119 and 5111.[1] The Ohio Department of Medicaid ("ODM")[2] proposes to implement the findings of cost report audits and/or patient days and patient liability audits conducted of Respondents. Accordingly, the Department issued Proposed Adjudication Orders (PAO), stating its reasons for such proposed action and informing Respondents of their right to a hearing. The parties stipulated that Respondents timely requested a hearing. (Tr., Pt. II, p. 23)

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[1] The provisions of R. C. Chapter 5111 were renumbered under R. C. Title 51 and a few repealed by 130th General Assembly, HB 59.

[2] The Ohio Department of Job and Family Services (ODJFS) issued Proposed Adjudication Orders to Respondents, who timely requested hearings. Since that time, pursuant to Am. Sub. HB 59 of the 130 General Assembly, eff. 7/1/2013, the Ohio legislature has created a new department, Ohio Department of Medicaid (ODM), which has assumed responsibility and authority over the Medicaid cases previously under ODJFS' jurisdiction. Throughout this Report and Recommendation, references made to the Ohio Department of Job and Family Services (ODJFS) or Office of Medical Assistance or Ohio Department of Medicaid (ODM) may be used interchangeably and for ease of reference may be called "the Department."

Summary of the Facts

Procedural Matters

Initially, the cases involved in this matter were divided between two hearing examiners. Originally, the above referenced hearing examiner was assigned CHS-Glenwell, Inc. Docket Nos. 09LTC17, 09LTC18, 09LTC19, CHS-Hamilton County, Inc. Docket Nos. 09LTC30, 09LTC31, 09LTC32, 09LTC33,[3] and Carington Health Systems Docket Nos. 09LTC24, 09LTC25[4]. Thereafter, the following cases were transferred to the above referenced hearing examiner and the parties agreed to consolidate the cases: CHS-Miami Valley, Inc. Docket Nos. 09LTC13, 09LTC14, 09LTCI5, 09LTC16, 09LTC34, 09LTC35, 09LTC36, 09LTC37, CHSGreater Cincinnati, Inc. Docket Nos. 09LTC20, 09LTC21, 09LTC22, 09LTC23, and CHS-Lake Erie, Inc. Docket Nos. 091 TC26, 09LTC27, 09LTC28, 09LTC29.

Prior to the consolidation, there were three days of hearings in the CHS-Glenwell, Inc. Docket Nos. 09LTC17, 09LTC18, 09LTC19, CHS-Hamilton County,

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[3] During the hearing, the parties agreed that the correct name for CHS-Hamilton County, Inc. is CHS-Ohio Valley, Inc. and that the caption of the case be amended to reflect this change. They noted that throughout the proceedings the correct Provider No. was used for the entities. (Tr., Pt. II, pp. 23-4)

[4] During the hearing, the parties agreed that the correct name for CHS-Carington Health Systems is CHS-Glenwell, Inc. and that the caption of the case be amended to reflect this change. They noted that throughout the proceedings the documents the correct Provider No. was used for the entities. (Tr., Pt. II, pp. 23-24)

Inc. Docket Nos. 09LTC30, 09LTC31, 09LTC32, 09LTC33, and Carington Health Systems Docket Nos. 09LTC24, 09LTC25 cases to address Respondents' challenge that the Department had not conducted audits. After consolidation, the parties agreed that the determination of whether an audit was conducted would apply to all the cases in consolidated case. (Stipulation of the Parties, No. 10)

During Part I of the hearing, sworn testimony was received from Daniel Wilkins, who had recently retired as Section Chief with ODJFS Bureau of Audit; Emily Hess, CPA, Senior Manager with Clifton Gunderson, Public Sector Healthcare Division; Kevin Kent, ODJFS External Audit Supervisor; Kierstyn Canter, ODJFS Audit Manager; Bert Cummins, CPA, designated representative for Respondents; and Christopher Carson, CPA, ODJFS Bureau Chief with Office of Fiscal and Monitoring Services. During Part II of the hearing, sworn testimony was received from Emily (Hess) Wale;[5] John Fleischer, CPA with the firm of Howard, Wershbale & Co.; Kierstyn Canter; John Hapchuk, an independent consultant who had worked with the U.S. Office of the Inspector General as a senior auditor and audit manager over the Medicare program; and Julie Evers, ODJFS Section Chief for Disability and Aging Policy. A court reporter was present for all days of the hearing.

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[5] Ms. Wale's former name was Emily Hess, who had testified during Part I of the hearing. In order to avoid confusion, Ms. Wale will be referred to as Ms. Hess in this Report and Recommendation. (Tr., Pt. II, p. 30)

The pages of the transcripts in Part I are numbered consecutively as follows: Vol. I - pp. 1-217; Vol. II -pp. 218-462; Vol. III-pp. 463-685. The pages of the transcripts in Part II are numbered consecutively as follows: Vol. I - pp. 1-7; Vol. II - pp. 8-313; Vol. III - pp. 314-454; Vol. IV - pp. 455-641; Vol. V - pp. 642-649; Vol. VI- pp. 650-817; Vol. VII - pp. 818-935; Vol. VIII - pp. 936-1082; Vol. IX - pp. 1083-1116. Throughout the Report and Recommendation, references to the transcript will be indicated as either Part (Pt.) I or II and then the page number.

Background

The Respondents in this matter are: CHS-Glenwell, Inc. [Glen Meadows (provider number 2429330)]; CHS-Ohio Valley, Inc. [Terrace View Gardens (provider number 2339384)]; CHS-Glenwell, Inc. [Wellington Manor (provider number 2429321)]; CHS-Miami Valley, Inc. [Vandalia Park (provider number 2339624)]; CHS-Miami Valley, Inc. [Franklin Ridge (provider number 2339688)]; CHS-Greater Cincinnati, Inc. [East Galbraith Health Care Center (provider number 2399033)]; and CHS-Lake Erie, Inc. [Carington Park (provider number 2339268)]. Respondents operate long-term care facilities, providing room, board and related nursing services to persons eligible for benefits under Ohio's Medicaid program. At the time at issue, ODJFS administered the Medicaid program pursuant to R.C. Chapter 5111 and Title XIX of the Social Security Act.

The Medicaid cost reports at issue in this matter are: 1) the calendar year 2003 Medicaid cost reports filed by Carington Park, Terrace View Gardens,

Vandalia Park, and Franklin Ridge; 2) the six-month cost report covering July 1, 2003, to December 31, 2003, filed by East Galbraith Health Care Center; and 3) the three-month cost reports covering December 1, 2003, to February 29, 2004, filed by Glen Meadows and Wellington Manor. The cost reports are collective referred to as "2003 cost reports." The Department also audited the patient days and patient liability for: 1) Carington Park, Terrace View Gardens, Vandalia Park, Franklin Ridge, East Galbraith Health Care Center for fiscal years 2003, 2004, 2005, and 2006; 2) Glen Meadows for fiscal years 2004, 2005, and 2006; and 3) Wellington Manor for fiscal years 2005 and 2006.

Audit/ Agreed Upon Procedures

During the Phase One of the administrative hearings requested by Respondents, the issue addressed was whether an audit was performed of the cost reports for three of the nursing homes.

In order to conduct an audit of a cost report, the person(s) conducting the audit reviews records and documents to ensure that the amounts reported in a provider's annual cost report are reported accurately, are allowable, documented, related to patient care and reasonable. Each cost in a cost report should be verifiable through documentation. (R.C. 5111.27; ODJFS Post Phase One Hearing Memorandum at 1)

ODJFS issued a Request for Proposal (RFP) seeking independent professional auditors to audit the calendar year 2003 Medicaid Nursing Facility Cost Reports. The RFP stated:

> The objective of the contracts resulting from this RFP are to provide ODJFS with the resources necessary to issue the statutory audit reports on cost reports of long term care facilities located in the State of Ohio and certified as providers under the Medicaid program.
>
> ODJFS is soliciting the services of qualified vendors to perform "Agreed-Upon Procedures" engagements with respect to ODJFS 2524 Medicaid cost reports...for CY2003. These engagements are to be performed in accordance with the provisions contained in this RFP and Attestation Engagements (AT) Section 600 of the AICPA (American Institute of Certified Public Accountants) Codification of Statements for Attestation Engagements.

(Tr., Pt. I, pp. 32, 42; State Exhibit 4, Wellington Manor p. 1672)

A committee with ODJFS' Bureau of Audits reviewed the responses to the RFPs and two firms were selected to conduct the cost report audits. One of these firms was Clifton Gunderson, which has "been performing cost report audits since the Medicaid program began in the mid-1960s ... and [has] served the Ohio Medicaid program since 1999." Emily Hess, who was the Supervisor Manager over the audits at question herein, testified that the audits of CHS at issue herein were conducted in the same manner that it had performed all other cost report audits in Ohio from 2000-2006. For over 12 years, Ms. Hess performed nothing but Medicaid cost report audits for Clifton Gunderson, including 900 - 1,000 in Ohio nursing

homes and hospitals. Whenever Clifton Gunderson had an engagement in Ohio, Ms. Hess was the manager assigned. (Tr., P. I, pp. 44-45, 230, 232-34, 319-20; State Exhibit 3, Wellington Manor p. 1559)

As stated in the RFP, the successful vendor was to perform "Agreed-Upon Procedures" engagements for the CY2003 cost reports. These Agreed-Upon Procedures set forth the scope and method to be utilized in conducting the cost report audits. The Department provided Clifton Gunderson training to review the procedures. Ms. Hess testified that Clifton Gunderson quite frequently performed Agreed-Upon-Procedures with attestation standards for all of their state clients, not just Ohio. She stated that in Agreed-Upon Procedure engagements, the client, i.e. Ohio or other states, would set forth procedures, which told Clifton Gunderson or other vendor what they need to be looking for. (Tr., Pt. I, pp. 148, 236-38)

An example of the reviewer's checklist for Agreed-Upon Procedures is set forth in State Exhibit 1, starting with planning, proceeding step by step all the way to the exit conference and completing the report. The description of the task is listed in one column and the work paper references are filled in as the work is completed. (Tr., Pt. I, pp. 248-49)

Ms. Hess stated that there are different procedures for full-blown financial based audits than for Agreed-Upon Procedures. She stated that the Agreed-Upon Procedures, especially in Ohio, is very in-depth. The purpose of an audit for a financial base is more of a balance sheet for the stockholders. The purpose of an

Agreed-Upon Procedures is to validate expenses and revenues. (Tr., Pt. I, pp. 498-99)

Clifton Gunderson assigned a partner, manager, supervisor and three field auditors to the audits at issue herein. In preparing to conduct the audit, Clifton Gunderson contacted CHS on March 1, 2006, over three months prior to the site visit scheduled for the week of June 12, 2006 at CHS' home office in Hamilton, Ohio, where CHS indicated the relevant documents were housed. In its letter, Clifton Gunderson stated: " To minimize disruptions to you and your staff during the field work phase of the review, please send the information listed on the attached letter to us by April 7, 2006." The attachment listed 32 categories for items to be produced. Furthermore, the list indicated the specific accounts in the cost report to be audited. Ms. Hess stated that CHS only produced documents responsive to one of the requests. (Tr., Pt. I, pp. 301-03; State Exhibit 9, Terrace View, p. 255)

Prior to the site visit, a second request was made for the general ledger accounts, which are comprehensive transaction lists. As stated in the original list, a review of the general ledger was necessary for the auditors to select invoices for the identified cost accounts to be audited. This second request for the general ledger was not honored until after the site visit had commenced. Moreover, during the week-long on-site field work, the auditors were waiting for documents that had been requested from CHS three months previously. (Tr., Pt. I, pp. 304-06)

On the last day of the field work, an exit conference was held and signed off by three Clifton Gunderson

staff and David McClellan, the Corporate Controller for CHS at the time. The signed form states: "All of the proposed adjustments *known at this time* were discussed with the Provider and a copy of the proposed adjustments was given to the Provider." (Tr., Pt. I, pp. 258, 307, 365-67; State Exhibit 9, Terrace View pp. 371-72 (italics in original))

At the exit conference, Clifton Gunderson asked CHS to sign the representation letter, which is part of the Agreed-Upon Procedures. CHS' consultant, Cummins, Krasik and Hohl, informed Clifton Gunderson that CHS would not sign it. Ms. Hess explained that Section 600 of the AICPA requires a representation letter, which is usually signed on the last day of field work. This letter is obtained from the entity being audited, in this case, Respondents. The letter should state, among other things, that, to Respondents' knowledge, "they provided all documentation to [Clifton Gunderson], that they were not aware of any fraud from the time that they submitted the cost report to the time" of the audit. Furthermore, they represent that they disclosed "anything else that...to their knowledge would be impactful to the engagement," i.e., anything that would impact or affect the costs reported in the cost reports. The letter used by Clifton Gunderson was a standard form, the template of which was provided by ODJFS. (Tr., Pt. I, pp. 239, 307-11, 506, 608)

Mr. Cummins stated that his firm advised CHS not to sign the form because there was language in the letter that was asking CHS "to agree to the sufficiency of the procedures that they [Clifton Gunderson]

performed." When Clifton Gunderson informed the Department of CHS' refusal to sign the letter, Clifton Gunderson was instructed to proceed with the audit as usual. (Tr., Pt. I, pp. 309-10, 548)

At the exit conference Clifton Gunderson also gave CHS a list of still outstanding documents, which was very similar to the list sent in March 2006. This list included, among other things, invoices, canceled checks and contracts, which would substantiate documentation for reported costs. Ms. Hess stated that providers are required to maintain proper documentation to support costs. Without that documentation, the cost would be removed from the cost report, resulting in an adjustment. The letter stated that if the items were not received by Clifton Gunderson by June 30, 2006, Clifton Gunderson would "make the required adjustments in [its] report to the Ohio Department of Job and Family Services." (Tr., Pt. I, pp. 306, 311, 315-16; State Exhibit 9, Terrace View pp. 377-80)

CHS provided some documentation for expenses prior to the deadline and Clifton Gunderson incorporated that information prior to issuing the proposed cost adjustment letter, which was sent to CHS along with supporting work papers of those adjustments. CHS was given seven days to respond to the report; otherwise, the finalized report would be sent to the Department. CHS did not respond and the draft adjustments were finalized to the Department. The Department received the Audit Input Document, copy of the proposed cost adjustments and papers to

support Clifton Gunderson's proposed cost adjustments. (Tr., Pt. I, pp. 105, 317-19)

After the Department received the finalized report from Clifton Gunderson, Kevin Kent[6] of the Department performed a high level review for accepting the actual audit from Clifton Gunderson. Mr. Kent explained that the review was not detailed. As Mr. Wilkins stated, the Department is not going back to re-perform the work of the contract auditors. Rather, the Department relied upon Clifton Gunderson to perform the detailed review of documentation. The Department is "just ensuring that what has been done is adequately documented in the working papers, and that the adjustments tie back to those working papers that are submitted." He merely reviewed the report to see that the Agreed-Upon Procedures were performed. (Tr., Pt. I, pp. 55, 326-28, 360; State Exhibit 9, Terrace View pp. 1133-41)

During the hearing, Mr. Kent showed the process he went through comparing his checklist of review criteria against the checklist with supporting documents initialed by the auditors as work was completed and, if necessary work papers. He conducted a similar quality review of all seven CHS audits. He stated that Clifton Gunderson passed the audit review he conducted. After Mr. Kent completed his review, then there was a final higher review and a final signoff to accept the audit as

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[6] Mr. Kent holds a Masters in Business Administration and a Masters in Accounting and Financial Management. (Tr., Pt. I, pp. 325-26)

done. (Tr., Pt. I, pp. 57, 106, 327-45, 347, 354-61; State Exhibits 1, 9)

The contract auditor's proposed cost adjustments were input into the Perseus system, which is the long-term care's operating system used to calculate payment rates. Proposed cost adjustments were made to the identified accounts where, based upon the audit, the Department believed the costs had been misreported. Mr. Wilkins testified that the procedures for audits, starting with the RFP, the contractor's work and the Department's process after receiving deliverables from the contract auditor have been the same since 1999. He stated that the Agreed-Upon Procedures have been modified periodically since 1999. He testified that Clifton Gunderson followed the Agreed-Upon Procedures as prescribed in the RFP. (Tr., Pt. I, pp. 59, 107, 118, 125-26, 155)

A final fiscal audit conference or exit conference may be conducted by the Department's Bureau of Audit "to try and resolve potential findings identified by the Department with the providers." This final fiscal audit conference, which is different than the exit conference held between Clifton Gunderson and CHS immediately after the on-site field work was completed in June 2003, is not mandatory. Ms. Canter stated that it is a courtesy provided by the Department to try to resolve proposed findings. After a cost report audit performed by either the Department or a contract independent auditor, the Department has the option to continue trying to work with the provider or to issue a Proposed Adjudication Order under R.C. Chapter 119 whereby the provider may request a hearing. One other option

is for the provider to pay the amount identified by the Department as due and owing. (Tr., Pt. I, pp. 411, 413-14, 416, 427)

In this case, Respondents requested final fiscal audit conferences. The Department, however, elected to issue Proposed Adjudication Orders, affording Respondents an opportunity to request a hearing under R.C. Chapter 119. Ms. Canter stated that attempts to meet and to obtain additional documents in order to try to resolve some of the matters were unsuccessful. One of the factors in the Department's decision to forego the final fiscal audit conferences was the difficulty in obtaining documents from CHS, not only during the audit itself, but also during the exit conference process. (Tr., Pt. I, pp. 191,416, 427-28, 439)

Days Audits

Days audits were also conducted of 1) Carington Park, Terrace View Gardens, Vandalia Park, Franklin Ridge, East Galbraith Health Care Center for fiscal years 2003, 2004, 2005, and 2006; 2) Glen Meadows for fiscal years 2004, 2005, and 2006; and 3) Wellington Manor for fiscal years 2005 and 2006. A days audit is "a review of the claims a provider has submitted for payment for a given fiscal year to determine that the Department had paid the provider appropriately. Some of the issues that are looked at in these audits include: 1) whether the Department paid for dates of service beyond the date of death of a recipient; 2) whether two institutions paid for the some dates of service for a recipient; 3) whether the Department paid for services when another payer should have paid first; 4) whether

patient resources were properly identified and applied. (Tr., Pt. I, pp. 108)

For fiscal year 2005 and prior, unless a provider notified the Department that a patient was not in the facility, the Department paid the provider for a full 30 days for that patient. Thereafter, the provider submitted a 9400 document identifying when a recipient was not in the facility or there was a change of resources or any circumstance that would indicate a provider was overpaid. Starting in fiscal year 2006, the provider submitted a claim for days of service provided to the Medicaid recipient. (Tr., Pt. I, pp. 110, 116)

Under both the systems -- before and after fiscal year 2005 – the Department looked at all claims paid to the institutional providers for a recipient to see if there were any overlaps in payment. There are no on-site reviews of the providers' records. A report is generated of any overlap. The days audits in the cases at issue herein were performed in the same manner as the audit at issue in *Meadowbrook Care Center v. Ohio Dept. of Job and Family Services* (10th Dist. 2007), 2007-Ohio-6534. (Tr., Pt. I, pp. 110-11, 113, 116-17, 159)

In its audits, ODJFS determined that some of the paid patient days were not covered Medicaid days of service. As stated in *Meadowbrook* at ¶ 14, examples of non-covered days include "days on which patients left [the provider's] facility for treatment elsewhere, or for which hospice costs were reimbursed directly to a hospice provider who furnished such care to a resident in [the provider's] facility."

ODJFS also looked at the amount Respondents collected from individual residents for their patient liability, which is "the individual's financial obligation toward the Medicaid cost of care for the medical institution." Ohio Admin. Code 5101:1-39-22.2(B). "The difference between the individual's patient liability and the monthly Medicaid cost of care is the Medicaid vendor payment amount." *Id*.

After performing the patient day/patient liability audits, ODJFS issued Combined Proposed Adjudication Orders (CPAO) for each open audit period for each of the Respondents. Each CPAO contained Reports of Examination, detailing the "calculation leading to the amount determined to be owed." State's Exhibits 43-46, 78-81, 105-108, 139-142, 169-172, 199-201, and 227-228. Respondents each timely requested an exit conference. Thereafter, ODJFS re-issued CPAO's for each facility for each open audit period, providing Respondents the opportunity to request a R.C. Chapter 119 hearing. State's Exhibits 47-50, 82-85, 109-112, 143-146, 173-176, 202-204, and 229-230. Each Respondent timely requested a Chapter 119 administrative hearing.

During discovery, CHS produced additional documentation, which was reviewed by ODJFS. As a result of this review, ODJFS made some adjustments and created new CPAOs with Reports of Examination. The revised reports reflecting the revised patient days and patient liability adjustments are set forth as follows:

Facility	**Patient Days/ Patient Liability FY Audit at Issue**	**State's Exhibit No.**	**Adjust-ments to Patient Liability**[7]	**Adjust-ments to No. of Paid Patient Days**
Caring-ton Park	FY 2003	242	$8,892.76 p. 19 (column C)	363.5 p. 8 (column E)
Carington Park	FY 2004	243	$5844.28 p. 20 (column C)	167 p. 8 (column E)
Carington Park	FY 2005	244a	$2,849.76 p. 21 (column C)	337 p. 5 (column E)

[7] The patient-liability adjustment amounts in this chart are not the amounts that CHS owes to ODM. The total amounts the CHS facilities owe to ODM are calculated by multiplying the correct number of patient days by the correct rate and subtracting the correct patient liability.

Carington Park	FY 2006	245b	$10,191.70 p. 19 (column C)	374.5 p. 5 (column E)
Terrace View Gardens	FY 2003	246	$6,461.32 p. 15 (column C)	296.50 p. 5 (column E)
Terrace View Gardens	FY 2004	247	$910.00 p. 10 (column C)	51 p. 6 (column E)
Terrace View Gardens	FY 2005	248	$945.00 p. 14 (column C)	19 p. 5 (column E)
Terrace View Gardens	FY 2006	249a	-$3,706.00 p. 10 (column C)	3.0 p. 5 (column E)
Vandalia Park	FY 2003	250	$8378.65 p. 17 (column C)	592.5 p. 6 (column C)

Vandalia Park	FY 2004	251	$0 p. 17 (column C)	198 p. 6 (column E)
Vandalia Park	FY 2005	252a	$528.42 p. 16 (column C)	161.5 p. 5 (column E)
Vandalia Park	FY 2006	253a	-$2990.20 p. 19 (column C)	441 p. 5 (column E)
Franklin Ridge	FY 2003	254	$1,404.98 p. 17 (column C)	175 p. 6 (column E)
Franklin Ridge	FY 2004	255	$2,385.00 p. 14 (column C)	93 p. 6 (column E)
Franklin Ridge	FY 2005	256a	$1,474.88 p. 15 (column C)	61.5 P. 5 (column E)

Franklin Ridge	FY 2006	257a	-$1.563.00 p. 9 (column C)	7 p. 5 (column E)
East Galbraith	FY 2003	258	$0.00 p. 9 (column C)	3 p. 6 (column E)
East Galbraith	FY 2004	259	$405.00 p. 12 (column C)	54.5 P. 6 (column E)
East Galbraith	FY 2005	260a	$0.00 p. 32 (column C)	45 p. 21 (column E)
East Galbraith	FY 2006	261a	$2827.64 p. 19 (column C)	867 p. 5 (column E)
Welling-ton Manor	FY 2005	262	$0.00 p. 10 (column C)	3.5 p. 5 (column E)

Wellington Manor	FY 2006	263	-$18.00 p. 10 (column C)	2.5 p. 5 (column E)
Glen Meadows	FY 2004	264	$994.62 p. 12 (column C)	11.5 p. 6 (column E)
Glen Meadows	FY 2005	265a	$0.00 p. 12 (column C)	16 p. 6 (column E)
Glen Meadows	FY 2006	266a	-$6,385.00 p. 8 (column C)	9 p. 5 (column E)

(Ohio Department of Medicaid's Post-Hearing brief, pp. 7-8; Tr., Pt. II, pp. 339-54)

Pursuant to Ohio Admin. Code 5101:6-50-09(A)(4), "Any audit report, report of examination, exit conference report, or report of final settlement issued by ODJFS and entered into evidence [in a R.C. Chapter 119 hearing] is to be considered *prime facie* evidence of what it asserts." Therefore, with the admission of the Reports of Examination, the State met its burden of proof and the burden fell to Respondent to refute the figures. Although Respondent's counsel objected to the

adjustments in the Reports of Examination and did not stipulate to the amounts, no evidence was presented to rebut ODJFS' *prime facie* evidence with respect to patient days and patient liability adjustments. *Vill. of Bellville v. Kieffaber*, (2007) 114 Ohio St. 3d 124 (Tr., Pt. II, p. 333)

Cost Reports and Audits

A. Overview

Each of the seven nursing facilities were required, pursuant to R.C. 5111.26(A)(1)(a) and Ohio Admin. Code 5101:3-20, in effect at the time, to file a cost report annually covering the calendar year or portion thereof in which the facility participated in the Medicaid program. These cost reports were to be prepared pursuant to rules and procedures established by ODJFS. *Id*; see Ohio Admin. Code Chapter 5101:3-3.

The cost reports filed by Respondents for calendar year 2003[8] were used by ODJFS to set the per diem rates for FY2005 and FY2006. (See State Exhibits 53, 88, 115, 150, 177, 207, 231) Pursuant to Ohio Admin.

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[8] Three of the facilities–East Galbraith Health Care Center, Glen Meadows, and Wellington Manor–filed partial calendar year 2003 cost reports because they did not operate for the entire year. East Galbraith Health Care Center filed a six-month cost report covering July 1, 2003, to December 31, 2003. Glen Meadows and Wellington Manor each filed 90-day cost reports covering December 2003, January 2004, and February 2004. Ohio Admin. Code 5101:3-3-20(H). However, the 2003 partial-year cost reports, in addition to the full calendar year 2003 cost reports filed by the other four providers, were used to set the per diem rates for FY 2005 and FY 2006. (State's Post-hearing Brief, fn. 6)

Code 5101:3-3-01(A), allowable costs, specifically, those costs that were actually incurred and were reasonable, are determined in accordance with a hierarchy of laws and rules as follows: The Ohio Revised Code, then the Ohio Administrative Code, then the Code of Federal Regulations, then the CMS HIM publications or Provider Reimbursement Manual publications and lastly, the general accepted accounting principles (GAAP). Ohio Admin. Code 5101:3-3-01; Ohio Admin. Code 5101:3-3-20. (Tr., Pt. II, pp. 95-96, 949-50; State Exhibit 275a)

Under this hierarchy, the Ohio Revised Code is applied first. If that source does not specifically address an issue, then the Ohio Administrative Code is applied. If that source does not specifically address an issue, then the Code of Federal Regulation is applied. If that source does not specifically address an issue, the Provider Manual or CMS Publication 15-1[9] is applied. And, finally, if there is complete silence, then general accepted accounting principles are applied. (Tr., Pt. II, pp. 957)

It is noted that the CFR and PRM are regulations and interpretive guidelines for reportable costs for Medicare cost reports. By including them in the hierarchy of sources to use in determining allowable costs for Medicaid nursing facilities, Ohio adopted these regulations to determine allowable costs for Medicaid cost reports in Ohio. 5101:3-3-01(A) There is

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[9] Publication 15-1, HIM-15-1, HIM-15, Provider Reimbursement Manual (PRM) and CMS-15-1 are different names for the same document. (Tr., Pt. II, p. 955)

nothing in the Ohio Administrative Code that states that certain provisions of the CFR or the PRM are not applicable to reporting costs in a cost report. Moreover, there is nothing in the CFR or the PRM that limits the application of any of the rules included therein to only Medicare or only Medicaid. (Tr., Pt. II, pp. 484-85, 958)

After conducting an audit of the 2003 cost reports, ODJFS determined that CHS had improperly reported costs in its cost reports. Many of the cost adjustments that Clifton Gunderson calculated during the audit were based upon insufficient documentation. During the discovery phase of this administrative hearing process, CHS provided ODJFS with additional information and documentation. After reviewing this documentation, adjustments were made to the cost adjustments. In some instances, the additional documents supported the reported costs, thereby enabling ODJFS to delete the adjustment. In other circumstances, the parties agreed that certain costs should not have been included in the cost report and the original cost adjustments remained. As a result of this review and the agreement of the parties, ODJFS and CHS stipulated to the new cost adjustments. These stipulated adjustments are set forth in State Exhibit 267a.[10] (Attached hereto as Attachment A and incorporated herein)

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[10] It is noted that paragraph 4 of the Stipulation of the Parties, there is reference to State Exhibit 267 as the document that summarizes the agreed upon cost adjustments. During the hearing, additional information was provided which resulted in recalculation of some of these stipulated cost adjustments. The parties agreed that the amended stipulated cost adjustment is State Exhibit 267a.

The parties, however, did not agree on all the cost adjustments. The disputed adjustments are set forth in State Exhibit 268. (Attached hereto as Attachment B and incorporated herein) Although the parties agree as to amounts set forth in State Exhibit 268, they disagree as to whether those costs should have been included in the first place. (Stipulations of the Paities, no. 5, attached hereto as Attachment C) These adjustments were made for direct-care consulting costs, found at State Exhibit 268, p. 1, indirect care consulting costs, found at State Exhibit 268, p. 2 and Cincinnati Reds tickets, found at State Exhibit 268, p. 3.

Accordingly, the disagreement between the parties relates to:

1. Inclusion of costs for direct-care consulting (account 6210) and indirect-care consulting (account 7215) in its 2003 cost reports

2. Inclusion of costs for Cincinnati Reds tickets in its 2003 cost reports

The parties have stipulated to the documents supporting these reported costs and also to the amounts in dispute. (State Exhibit 268 and Stipulation of Parties)

B. Cost Reports

Cost reports, which are based on a calendar year, are the mechanism by which nursing home facilities report their operating costs to the State. These cost reports are prepared by the nursing facilities and submitted to the State. Providers use the accrual basis of accounting when reporting costs on a cost report.

Within each cost report are separate cost centers: direct care, indirect care, capital cost, other protected. Each of these cost centers is divided into cost accounts. The Ohio Administrative Code outlines what is included in each cost account and cost center. The State then uses the cost reports in a rate-setting formula to establish a per diem rate, which is the amount that a facility is paid for each person in the facility. The sum of the various cost accounts comprises the total for the respective cost center. The totals of the cost centers are used to determine that provider's rate. There is a different rate for each cost center. (Tr., Pt. II, pp. 92-94, 96-97, 283-84, 376, 1012)

Over the years, Ohio has used different reimbursement systems for Medicaid as it relates to nursing homes. Prior to 1991, Ohio used a retrospective cost settlement system. Under this system, the cost report data was used "to establish ceilings, calculated rates, multiplied the rate calculated by the number of Medicaid days, and compared that to the total payments made during the calendar year period." If the State paid the nursing home more than it should have, the nursing home would repay the money. If the Sate did not pay the nursing home as much as the cost, the State would pay additional funds to the provider. (Tr., Pt. II, pp. 746, 1004, 1008)

In 1992, the State started transitioning into a prospective cost based system, which came into place in 1994 and continued for 11 years, through FY 2005. In the prospective cost-based system, a rate was established for each facility, based upon its costs (subject to ceilings). This rate was established prior to

the beginning of the fiscal year for which it became effective and there was no reconciliation as to "what the provider actually spent in that period." (Tr., Pt. II, pp. 1009-10)

Julie Evers with the Department's Office of Ohio Health Plans, explained the prospective cost-based system in a little more detail. Cost data was collected from calendar year cost reports and an 18-month inflation factor to the costs on that cost report was applied to establish a rate for the subsequent fiscal year. The cost reports for 2003 were used in establishing the rates for FY 2005, which started July 1, 2004. Ms. Evers said that under the prospective cost-based reimbursement system, the rate for nursing facilities were based upon actual costs. Each facility had its own unique rate. (Tr., Pt. II, pp. 746, 1011, 1029-30)

In 2005, the Ohio legislature passed laws which changed the reimbursement system from the cost-based prospective reimbursement system to a price-based prospective system. During the transition period, the rates in FY 2006 were the same as those in FY 2005. In FY 2007, the new rates under the price-based prospective system went into effect. (Tr., Pt. II, pp. 1030-31)

Under the price-based prospective system, the State pays "similarly-situated homes the same price subject to case mix adjustments." Rather than looking at the facility's costs, the State looks at "the peer group experience to establish the rate components," while still starting with a calendar year cost report and applying an 18-month inflation factor. (Tr., Pt. II, p. 1034)

In order to claim any expense in a cost report, the facility must have documentation, such as general ledgers, trial balance, invoices, cancelled checks, bank statements, contracts, leases, and loans, to substantiate the expense. If the provider does not supply documentation to substantiate the costs, that cost is eliminated or disallowed due to lack of documentation. An adjustment is made on the Proposed Cost Adjustment Reports form. Each adjustment reduces the amount that was originally reported by the provider on its cost report. (Tr., Pt. II, pp. 94-95, 98-103)

After the cost report audits are conducted,[11] any audit adjustments are entered into the Perseus system, which also contains cost reports and sets the initial rates for nursing homes. After the adjustments are entered, Perseus calculates a new rate. These revised rates are incorporated into combined proposed adjudication reports[12] (CPA report), which are sent to nursing homes notifying them of the amount, if any, owed back to the State. (Tr., Pt. II, pp. 377-78)

Direct Care and Indirect Care Consulting Costs

A. *The Contracts*

Each of the CHS facilities at issue herein contracted with Strategic Nursing Systems ("Strategic") and/or

[11] One of the major purposes of the audit it to substantiate a cost claimed on the cost report. (Tr., Pt. II, pp. 97)

[12] Combined Proposed Adjudication reports are also called final fiscal audit reports. (Tr., Pt. II, pp. 378)

Providers Choice Administrative Services ("Providers" or "Providers Choice") for consulting services. Most of these contracts consisted of two parts: Annual Services and Enhanced Services. The Enhanced Services portion of the contract was to pay Strategic and/or Providers "additional fees as specified in Attachment A" of the contract. (See, eg., State Exhibit 57, p. 5)

Under the "Annual Services" part of the contracts, the facilities were invoiced monthly. Each of the monthly invoices stated that payment was due upon receipt of invoice. The facilities paid these invoices by check.

Under the "Enhanced Services" part of the contracts (Attachment A to the contract), rather than sending monthly invoices, Strategic and Provider invoiced the facilities on December 31, 2003 for the entire amount for services provided from January 1, 2003 through December 31, 2003. These invoices stated that payment was due upon receipt of invoice.

During the audit, the auditor disallowed these costs because there was inadequate documentation and there was a related party issue. For example, Ms. Hess testified that during the audit, the auditors asked for accounts with respect to Strategic and they looked for specific transactions in account 6210. They did not get invoices, canceled checks, promissory notes, payments of checks on the promissory notes (Tr., Pt. II, pp. 206-08)

Since CHS presented documentation during discovery, ODM is no longer proceeding on the issue of inadequate documentation or related party issue. The

additional documentation, however, revealed an issue with liquidation of liabilities. This issue was not identified originally because CHS failed to provide the documentation (Tr., Pt. II, p. 16)

With respect to cost account 6210, the parties stipulated:

A. CHS – Lake Erie, Inc. d.b.a. Carington Park, provider number 2339268, entered into an agreement with Strategic Nursing Systems, Inc., at State's Exhibit 57. The costs associated with this consulting agreement were reported in account 6210. Strategic Nursing Systems, Inc. invoiced Carington Park monthly for the consulting fees and Carington Park paid each invoice by check as shown in State's Exhibit 58. The consulting agreement (State's Exhibit 57) contained an Attachment A for Enhanced Services, with an additional consulting fee that was due on December 31, 2003, that was invoiced by Strategic Nursing Services as shown by State's Exhibit 59. Carington Park issued an installment promissory note for the December 31, 2003 for the Enhanced Services invoice, State's Exhibit 60. The payments of the installment promissory note were per the note's terms and were by checks at State's Exhibit 61.

B. CHS – Hamilton County, Inc. d.b.a. Terrace View Gardens, provider number 2339384, entered into an agreement with Strategic Nursing Systems, Inc. at State's Exhibit 92. The costs associated with this consulting agreement were reported in account 6210. Strategic Nursing Systems, Inc. invoiced Terrace View Gardens monthly for the consulting

fees and Terrace View Gardens paid each invoice by check as shown in State's Exhibit 93. The consulting agreement (State's Exhibit 92) contained an Attachment A for Enhanced Services, with an additional consulting fee that was due on December 31, 2003, that was invoiced by Strategic Nursing Services as shown by State's Exhibit 94. Terrace View Gardens issued an installment promissory note for the December 31, 2003 Enhanced Services invoice, State's Exhibit 95. The payments of the installment promissory note were per the note's terms and were by checks at State's Exhibit 96.

C. CHS – Miami Valley, Inc. d.b.a. Franklin Ridge, provider number 2339688, entered into an agreement with Strategic Nursing Systems, Inc. at State's Exhibit 119. The costs associated with this consulting agreement were reported in account 6210. Strategic Nursing Systems, Inc. invoiced Franklin Ridge monthly for the consulting fees and Franklin Ridge paid each invoice by check as shown in State's Exhibit 120. The consulting agreement (State's Exhibit 119) contained an Attachment A for Enhanced Services, with an additional consulting fee that was due on December 31, 2003, that was invoiced by Strategic Nursing Services as shown by State's Exhibit 121. Franklin Ridge issued an installment promissory note for the December 31, 2003 Enhanced Services invoice, State's Exhibit 122. The payments of the installment promissory note were per the note's terms and were by checks at State's Exhibit 123.

D. CHS – Miami Valley, Inc. d.b.a. Vandalia Park, provider number 2339624, entered into an agreement with Strategic Nursing Systems, Inc. at State's Exhibit 154. The costs associated with this consulting agreement were reported in account 6210. Strategic Nursing Systems, Inc. invoiced Vandalia Park monthly for the consulting fees and Vandalia Park paid each invoice by check as shown in State's Exhibit 155.

E. CHS-Greater Cincinnati, Inc., d.b.a. East Galbraith Health Care Center, provider number 2399033, entered into an agreement with Strategic Nursing Systems, Inc. at State's Exhibit 181. The costs associated with this consulting agreement were reported in account 6210. Strategic Nursing Systems, Inc. invoiced East Galbraith monthly for the consulting fees and East Galbraith paid each invoice by check as shown in State's Exhibit 182. The consulting agreement (State's Exhibit 181) contained an Attachment A for Enhanced Services, with an additional consulting fee that was due on December 31, 2003, that was invoiced by Strategic Nursing Services as shown by State's Exhibit 183. East Galbraith issued an installment promissory note for the December 31, 2003 Attachment A Enhanced Services invoice, State's Exhibit 184. The payments of the installment promissory note were per the note's terms and were by checks at State's Exhibit 185. The consulting agreement (State's Exhibit 181) also contained an Attachment B for Enhanced Services, with an additional consulting fee that was due on December 31, 2003, that was invoiced by Strategic Nursing Services as shown by

> State's Exhibit 186. East Galbraith issued an installment promissory note for the December 31, 2003, Attachment B Enhanced Services invoice, State's Exhibit 187. The payments of the installment promissory note were per the note's terms and were by checks at State's Exhibit 188.

(Stipulation of the Parties, ¶ 6)

With respect to cost account 7215, the parties stipulated:

> A. CHS – Lake Erie, Inc. d.b.a. Carington Park, provider number 2339268, entered into an agreement with Providers Choice Administrative Services, Inc., at State's Exhibit 63. The costs associated with this consulting agreement were reported in account 7215. Providers Choice Administrative Services, Inc. invoiced Carington Park monthly for the consulting fees and Carington Park paid each invoice by check as shown in State's Exhibit 64. The consulting agreement (State's Exhibit 63) contained an Attachment A for Enhanced Services, with an additional consulting fee that was due on December 31, 2003. Carington Park issued an installment promissory note for the December 31, 2003 Enhanced Services fee, State's Exhibit 65. The payments of the installment promissory note were per the note's terms and were by checks at State's Exhibit 66.
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> B. CHS – Hamilton County, Inc. d.b.a. Terrace View Gardens, provider number 2339384, entered into an agreement with Providers Choice Administrative Services, Inc., at State's Exhibit 98. The costs

associated with this consulting agreement were reported in account 7215. Providers Choice Administrative Services, Inc. invoiced Terrace View Gardens monthly for the consulting fees and Terrace View Gardens paid each invoice by check as shown in State's Exhibit 99. The consulting agreement (State's Exhibit 98) contained an Attachment A for Enhanced Services, with an additional consulting fee that was due on December 31, 2003. Terrace View Gardens issued an installment promissory note for the December 31, 2003, Enhanced Services fee, at State's Exhibit 100. The payments of the installment promissory note were per the note's terms and were by checks at State's Exhibit 101.

C. CHS – Miami Valley, Inc. d.b.a. Franklin Ridge, provider number 2339688, entered into an agreement with Providers Choice Administrative Services, Inc., at State's Exhibit 125. The costs associated with this consulting agreement were reported in account 7215. Providers Choice Administrative Services, Inc. invoiced Franklin Ridge monthly for the consulting fees and Franklin Ridge paid each invoice by check as shown in State's Exhibit 126. The consulting agreement (State's Exhibit 125) contained an Attachment A for Enhanced Services, with an additional consulting fee that was due on December 31, 2003. Franklin Ridge issued an installment promissory note for the December 31, 2003, Enhanced Services fee, at State's Exhibit 127. The payments of the installment promissory note were per the note's terms and were by checks at State's Exhibit 128.

D. CHS – Miami Valley, Inc. d.b.a. Vandalia Park, provider number 2339624, entered into an agreement with Providers Choice Administrative Services, Inc., at State's Exhibit 157. The costs associated with this consulting agreement were reported in account 7215. Providers Choice Administrative Services, Inc. invoiced Vandalia Park monthly for the consulting fees and Vandalia Park paid each invoice by check as shown in State's Exhibit 158. The consulting agreement (State's Exhibit 157) contained an Attachment A for Enhanced Services, with an additional consulting fee that was due on December 31, 2003. Vandalia Park issued an installment promissory note for the December 31, 2003, Enhanced Services fee, at State's Exhibit 159. The payments of the installment promissory note were per the note's terms and were by checks at State's Exhibit 160.

E. CHS-Greater Cincinnati, Inc., d.b.a. East Galbraith Health Care Center, provider number 2399033, entered into an agreement with Providers Choice Administrative Services, Inc., at State's Exhibit 190. The costs associated with this consulting agreement were reported in account 7215. Providers Choice Administrative Services, Inc. invoiced East Galbraith monthly for the consulting fees and East Galbraith paid each invoice by check as shown in State's Exhibit 191. The consulting agreement (State's Exhibit 190) contained an Attachment A for Enhanced Services, with an additional consulting fee that was due on December 31, 2003. East Galbraith issued an installment promissory note for the December 31,

> 2003, Enhanced Services fee, at State's Exhibit 192. The payments of the installment promissory note were per the note's terms and were by checks at State's Exhibit 193.

(Stipulation of the Parties, ¶ 7)

Some of the monthly invoices for services under the annual contracts were paid more than one year after the end of the relevant cost-reporting period. The following chart shows that the invoices were issued in November and/or December 2003. The checks to pay these invoices, however, were not paid to Strategic until March 2005 and/or April 2005.

Facility	Invoice Month	Date Checks were Issued	End of Cost-Reporting Period	State's Exhibit Number	CHS's Exhibit Number
Terrance View Gardens	December 2003	March 2005	12/31/2003	State's Exhibit 93, pp. 23-24	CHS Exhibit RRR, TVG000734-000735
Franklin Ridge	December 2003	March 2005	12/31/2003	State's Exhibit 120 pp. 23-24	CHS Exhibit FFFF, FR001194-001195
Vandalia Park	December 2003	March 2005	12/31/2003	State's Exhibit 155 pp. 23-24	CHS Exhibit NNN, CP000727-00728[13]

[13] When CHS produced documents during discovery, it inadvertently labeled Vandalia Park documents with the Bates-Number prefix CP and Carington Park documents with the Bates-Number prefix VP.

Caring-ton Park	Nove-mber 2003 and Dece-mber 2003	March 2005 and April 2005	12/31/ 2003	State's Exhibit 58, pp. 21-25	CHS Exhibit ZZZ, VP000 863-000866
Glen Mead-ows	Dece-mber 2003	March 2005	2/29/ 2004	State's Exhibit 208 pp. 3-4	CHS Exhibit WW, GM009 27-00928
Wellin-gton Manor	Dece-mber 2003	March 2005	2/29/ 2004	State's Exhibit 234 pp. 4-5	CHS Exhibit HHH, WELL 00065 7-000 658

(State Post-hearing Brief at 14)

Based upon the fact that they were not paid within one year after the end of the cost reporting period, the Department disallowed these costs in the FY2003 cost reports. These amounts are included in the Stipulated Amount columns on State Exhibit 268, pp.1-2 (attached hereto as Attachment B)

In addition to the facilities set forth in the above chart, for disallowance of seven payments on the "Annual Services" monthly invoices, one facility, East

Galbraith, paid all of the monthly invoices for Annual Services for Providers Choice starting in January 2005. These payments were also disallowed in the FY2003 cost report because the payments were not made within one year after the end of the cost reporting period. These amounts are also included in the Stipulated Amount columns on State Exhibit 268, pp.1-2 (attached hereto as Attachment B) (Stipulation of the Parties; State Exhibit 181, pp. 5, 11; State Exhibits 190, 191)

Some of the facilities reported costs in their cost report for the "Enhanced Services." On December 31, 2003, Strategic and/or Providers Choice issued invoices for the total amount of the "Enhanced Services" contracts. The invoice stated "Payment Due Upon Receipt of Invoice." That same day, December 31, 2003, the facilities issued promissory notes in the exact amount of the invoices. Payment on these promissory notes were not to commence until mid-2005. Therefore, none of the facilities' assets were transferred until 2005, over one year from the end of the 2003 cost report period. In July 2005, the facilities began issuing monthly checks to pay the promissory notes.

B. Liquidation of Liabilities

One of the cost accounts in dispute is 6210, which is consulting and management costs related to direct care. For purposes of illustration, during the hearing, ODM used the example of one of the Carington Park facilities, whose cost report was State Exhibit 53. Carington Park reported $2,398,356 in this cost account. Ms. Hess testified that during the audit they sampled "from to vouch expenses, and [they] selected a variety of different journal entries and transactions to

test these amounts." Although Carington supplied the auditors with some invoices and a consulting agreement, Ms. Hess stated that they received very little documentation, even after requesting documentation on this transaction. As a result, an adjustment was made to this account for lack of documentation and related party matters[14]. Ms. Hess testified that the lack of documentation included lack of information regarding the related party issue. (Tr., Pt. II, pp. 97, 104-08, 207; State Exhibit 54)

The consulting agreement between Carington Park and Strategic Nursing Systems provided for Compensation of Consultant: "For the full and efficient performance of its duties and responsibilities hereunder, Consultant shall be paid annually $1,550.00 per licensed bed (the "Consulting fee"), payable in equal installments on or before the 20th day of each month." Ms. Hess stated that Carington provided few, if any, copies of these invoices. (Tr., Pt. II, pp. 108-09; State Exhibit 57, p. 5)

Through discovery in this matter, invoices and checks were received and are set forth in State Exhibit 58. The invoices were dated January 31, 2003, February 29, 2003, March 31, 2003, April 30, 2003, May 31, 2003, June 30, 2003, July 31, 2003, August 31,

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[14] The related party issues were based upon the fact that the 2004 tax returns of the owners of Carington also listed ownership of Strategic Consulting, which was one of the entities that Carington entered into contract with for consulting services in cost account 6210. This issue was later dropped by the Department after receiving documentation during the discovery phase of this case. (Tr., Pt. II, pp. 106-07)

2003, September 30, 2003, October 31, 2003, November 30, 2003, and December 31, 2003. The checks, in the amount of $26,738, were dated September 22, 2003, October 24, 2003, November 24, 2003, December 16, 2003, January 22, 2004, February 24, 2004, March 18, 2004, May 20, 2004, June 19, 2004, July 23, 2004, March 28, 2005 and April 26, 2005. (State Exhibit 58)

Ms. Hess testified that all of these transactions, except the two checks issued in 2005, would have been allowable in the cost report. She stated that funds must be expended within one year of the end of the cost reporting period. Therefore, the checks issued on March 28, 2005 and April 26, 2005 would be disallowed. (Tr., Pt. II, pp. 110-11, 116-17)

There was also an Attachment to this contract for Enhanced Services for the period of January 1, 2003 to December 31, 2003. Under this contract, Strategic Nursing Systems charged Carington Park $10,024 per licensed bed. Since there were 207 beds, the amount of the contract for enhanced services was $2,075,000. The contract specifically stated that the "Invoicing will be submitted on December 31, 2003." (State Exhibit 57)

Therefore, on December 31, 2003, Strategic Nursing Systems submitted an invoice for service provided for the 2013 calendar year in the amount of $2,075,000. The invoice stated "PAYMENT DUE UPON RECEIPT OF INVOICE" Ms. Hess stated that this debt was a short term liability. She said that in order to be an allowable expense, Carington Park would have to pay Strategic for the goods and services within a year of the end of the cost reporting period, i.e. December 31, 2004. The auditors did not receive a copy of this invoice

during the audit. (Tr., Pt. II, pp. 118-20; State Exhibit 59, p. 4)

On December 31, 2003, Carington Park executed an Installment Promissory Note with Strategic in the amount of "$2,075,000, with interest from July 1, 2005 on the unpaid principal at the rate of 5.00% per annum." The promissory note further stated: "The unpaid principal and accrued interest shall be payable in monthly installments of $62,189.61, beginning on August 01, 2005, and continuing until July 01, 2008, (the "Due Date"), at which time the remaining unpaid principal and interest shall be due in full." A copy of this promissory note was not produced during the audit. (State Exhibit 60)

The promissory note itself states that payments are to commence August 2005, which is more than 12 months after the close of the 2003 cost reporting period. State Exhibit 61 contains copies of monthly checks in the amount of $62,189.61 for payments on the promissory note. The first check on payment of the loan is dated July 26, 2005. It is noted that the promissory note was to be paid in full by July 1, 2008, but checks in the amount of $62,189.61 continued to be issued in August, September, October and December 2008. None of these checks in State Exhibit 61 were produced during the audit. (Tr., Pt. II, p. 120)

Ms. Hess testified that if they had been produced, the cost would have been disallowed based upon 42CFR 413.100 and Provider Reimbursement Manual section 2305. Ms. Hess further explained that the checks which were written in 2005 would be allowed on the 2005 cost report and those written in 2006 would be allowed in

the 2006 cost report and similarly for 2007 and 2008.[15] (Tr., Pt. II, pp. 121, 128-34)

Ms. Hess was asked if it would have made a difference if Carington had received a loan from a bank for $2,075,000 and then given that money to Strategic. She stated that since the vendor, Strategic, actually received funds to pay for the goods and services, that cost would have been allowed in the 2003 cost report. By providing Strategic a promissory note in lieu of money, however, Strategic did not receive any funds or payment for the goods and service until actual payments commenced in 2005. Ms. Hess stated that the difference is the actual expenditure of funds. (Tr., Pt. II, pp. 135-36)

Ms. Hess stated that by placing the costs for Enhanced Services in cost account 6210, Carington Park classified these costs as short term. Long term liabilities are reported on the balance sheets and interest associated with long-term liability is usually in the capital component. Ms. Hess stated that the current portion of a long-term liability is "technically considered a short term liability as well and it's due within 12 months of that date and time." The long term portion is greater than 12 months. (Tr., Pt. II, pp. 151-52)

The costs in cost account 7215 involve contracts with Provider's Choice Administrative Services. For purposes of illustration, during the hearing, the Department used the example of one of the Carington

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[15] This is supposing that Ohio had the same reimbursement system. The system, however, was changed in FY2006.

Park facilities. In the 2003 cost report, Carington Park reported $694,177. During the audit, the auditors only received a few invoices. The auditors disallowed $625,000 based upon insufficient documentation and related parties transactions. (Tr., Pt. II, pp. 137; State Exhibit 54)

Carington Park entered into an agreement for indirect care consultant services with Providers Choice. Carington Park agreed to pay Provider's Choice $550 per licensed bed, payable 30 days from the date of the invoice. Since there were 207 licensed beds, the monthly charge was $9,488. State Exhibit 64 includes the invoices, starting on January 31, 2003 through December 31, 2003, with the corresponding checks to pay the invoices. The auditors did not receive any of these documents during the audit. (Tr., Pt. II, pp. 139-41; State Exhibit 63)

As with Strategic, Carington Park entered into an Additional Services ("Enhanced Services") agreement in which Providers Choice charged $2,730 per licensed bed. As with Strategic, the contract specifically stated that invoicing will be submitted on December 31, 2003. (State Exhibit 63, pp. 6-7)

On December 31, 2003, Carington Park executed an Installment Promissory Note with Providers Choice in the amount of " $565,000, with interest from February 1, 2005 on the unpaid principal at the rate of 5 .00% per annum." The promissory note further stated: "The unpaid principal and accrued interest shall be payable in monthly installments of $24,787.34, beginning on February 1, 2005, and continuing until January 1, 2007, (the "Due Date"), at which time the remaining

unpaid principal and interest shall be due in full." A copy of this promissory note was not produced during the audit. (Tr., Pt. II, pp. 142-44; State Exhibit 65)

The promissory note itself states that payments are to commence February 2005, which is more than 12 months after the close of the 2003 cost reporting period. State Exhibit 66 contains copies of monthly checks in the amount of $24,787.34 for payments on the promissory note. The first check on payment of the loan is dated March 29, 2005 and continued through December 18, 2006. None of these checks in State Exhibit 66 were produced during the audit. (Tr., Pt. II, p. 145)

Although ODM counsel just went through the promissory note payment and time of payments analysis for Carington Park, Ms. Hess testified that there was a same scenario with the other facilities. She stated that the auditors received approximately the same amount of documentation for the other facilities as for Carington Park. Therefore, at the time of the audit, the costs were disallowed for lack of documentation and what the auditors thought was a related party issue. After reviewing the documentation received during discovery in this matter, however, the liquidation of liabilities issues became the basis for disallowance. Ms. Hess testified that if the contracts, invoices, promissory notes and checks had been produced during the audit, the cost would have been disallowed based upon 42CFR 413.100 and Provider Reimbursement Manual section 2305. Moreover, she testified that the same analysis would apply to all the

other Carington Health Systems facilities at issue in this case. (Tr., Pt. II, pp. 144-45)

In August 2004, prior to making any payments on these promissory notes, Carington Health Systems purchased Strategic for $4.6 million. Therefore, CHS "owed the money to themselves. Strategic has a receivable of $12 million. And when it was acquired, it became part of the combination, and they eliminated." (Tr., Pt. II, p. 894)

Respondents presented the testimony of John Fleischer and John Hapchuk to address the issue of liquidation of liabilities.

John Fleischer has been a certified public accountant since 1982. His firm, Howard, Wershbale & Co., does a lot of work for nursing homes. Providers Choice, which is currently one of the clients of Mr. Fleischer's firm,[16] is one of the companies that received promissory notes that are at issue in this case. (Tr., Pt. II, pp. 226-27)

Mr. Fleischer also does consulting to the long-term care industry and has been involved with a "couple thousand" Medicaid audits and audit settlements. He acknowledged that he does not perform the cost reports for nursing home facilities, but reviews them for other members of his firm. He said, however, he did prepare them about 20 years ago. He has also served as

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[16] Mr. Cummins, the designated representative for Respondents in this matter, and a CPA, merged with Mr. Fleisher's firm in January 2011. (Tr., Pt. II, p. 225)

chairman of the Ohio Health Care Association's[17] payment committee. (Tr., Pt. II, pp. 218-19, 228)

Prior to presenting his testimony in this matter, Mr. Fleischer did not review any of the exhibits in this case. He had not seen any of the contracts between Carington Park and Strategic. He did, however, look at some of Mr. Cummins' work papers. (Tr., Pt. II, pp. 228-30)

Mr. Fleischer has seen many instances in which providers report costs which have been paid by a negotiable instrument, including in the 1980's when providers got "lines of credit that they couldn't pay and then would refinance those into long-term debt." He explained that on the cost report there are two lines of interest - the working capital interest and the long-term capital asset interest. Generally, the working capital interest resulted from facilities being unable to pay their vendors and refinance or convert into long-term debt or note with a bank or sometimes the vendors themselves. Mr. Fleischer stated that the entire expense would be recorded on the cost report since it was incurred in that year and it was liquidated by a long-term note. He admitted that this was not a common practice and, in his experience has occurred less than six times over the course of 20 years. He further clarified that if he were looking only at such transactions with vendors, it would be even more limited. (Tr., Pt. II, pp. 221-24)

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[17] Ohio Health Care Association is the trade association which represents nursing homes and assisted living facilities. (Tr., Pt. II, pp. 227-228)

When asked whether there was a specific rule in the CFR which addresses costs not paid in the year they were incurred, Mr. Fleischer stated there was a rule regarding liquidation of liabilities. When asked if he had an understanding of the liquidation of liabilities rule, he responded that he had "looked at it a little bit." He said he has never seen the rule applied in the manner the Department has applied it in this case. Moreover, he was uncertain whether the rule was applicable in Medicaid. (Tr., Pt. II, pp. 221,232)

He stated that cost reporting is to be on the accrual basis of accounting and, in accordance with generally accepted accounting principles, when costs are reported in the year that they incur. He acknowledges that 42 CFR 413.100 is a rule dealing with "special treatment of certain accrued costs." Mr. Fleischer acknowledged that under this rule, in the case of accrued costs for which a provider has not actually expended funds during the current cost reporting period, such costs are not recognized unless the related liabilities are liquidated timely. He defined liquidation of liability as a payment of cash, transfer of other assets or a presentation of a longterm debt instrument, such as a promissory note. (Tr., Pt. II, pp. 232-33, 237-39)

Mr. Fleischer also acknowledged that there is a liquidation of liabilities rule in the Provider Reimbursement Manual (PRM). Although the PRM rule is similar to the 42 CFR 413.100, the PRM is more explicit, requiring that liquidation "must be made by check or other negotiable instrument, cash or legal transfer of assets such as stocks, bond, real property, etc. Where liquidation is made by check or other

negotiable instrument, these forms of payment must be redeemed through an actual transfer of the provider's assets within the time limits specified in this section." (PRM 2305)

Mr. Fleischer stated that if a facility takes "an ordinary expense and makes it part of a long-term liability, ... the liability has been liquidated within one year." He admitted, however, that if an invoice is due immediately, it is a short-term liability. The invoices for Strategic and Providers Choice state "Payment due upon receipt of invoice." (Tr., Pt. II, pp. 241-42, 258, 278)

Mr. Fleischer was given a scenario of Carington Park, getting a promissory note from the bank, taking the cash it got from the bank and giving the cash to Strategic. Mr. Fleischer agreed that in this scenario there was a transfer of funds. In the herein matter, however, Strategic did not get any money in their account as a result of the promissory note. Strategic took the note in lieu of cash. The first time Strategic got any money under this contract was July 2005. (Tr., Pt. II, pp. 295, 302-06)

Mr. Fleischer acknowledged that a promissory note does not make any actual transfer of provider assets. A check, however, is a transfer of funds. The first check issued to pay the promissory note was dated July 26, 2005. He agreed that the promissory note for $2,075,000 did not transfer any assets from Carington to Strategic. Strategic took the note in lieu of cash. The promissory note did, however, liquidate the liability for purposes of GAAP and reporting financial statements. A cost report, however, is not a report of the financial

status of a provider entity. (Tr., Pt. II, pp. 259-61, 281; State Exhibit 61, p. 1)

PRM 2305 states that where liability is not liquidated with the 1-year time limit, "the cost incurred for the related goods and services is not allowable in the cost reporting period when the liability is incurred, but is allowable in the cost reporting period when the liquidation of the liability occurs." (emphasis added) Mr. Fleischer stated that under the rule, the facility would get its costs back in a later year. Therefore, under this rule, Carington Park would report the payments made on the promissory notes during the year that the payments were made. So for example, the first payment on the promissory note to Strategic which was made on July 26, 2005, in the amount of $62,189.61, would have been reported on the 2005 cost report. (Tr., Pt. II, pp. 248-49)

However, there was a change in the reimbursement system in 2004, and 2005 cost reports were not used to establish rates. Mr. Fleischer said "2003 was a year upon which rates were going to be established and we did not know that 2004 was not going to be used." Therefore, looking in hindsight, Mr. Fleischer stated that this provision of PRM should not apply because there would be "no way to get that reimbursement back at a later time." (Tr., Pt. II, pp. 245, 300-01)

He admitted that had the reimbursement system not changed, the cost reports for 2004 would set the rate for FY2006, and 2005 cost report for FY2007, etc. Therefore, the problem is that there was a change in the law on how the rate was set. "They changed the reimbursement system legislatively where they weren't

going to use the cost report anymore and that's part of why these rules don't make sense. These rules are designed for an ongoing reimbursement system." He admitted that the rules made sense prior to the change in legislation. (Tr., Pt. II, pp. 250-51)

Respondents also presented the testimony of John Hapchuk, who worked for the U. S. Office of the Inspector General (OIG) in the Office of Audit Services for 40 years. He held various positions of increasing responsibility, serving as a senior auditor and audit manager over the Medicare program. He also served as a Medicaid Audit Manager. Since his retirement in 2010, he has served as an independent consultant. He stated that during his career with the OIG, he answered questions about "the application of Medicare rules and the reimbursement manual." He admitted that he "can speak more from Medicare than Medicaid." (Tr., Pt. II, pp. 461-76, 488-89, 552; Respondent Exhibit NNNN)

Mr. Hapchuk was hired by Respondent to look at the liquidation of liabilities rule and give his opinion as to its applicability to the consulting costs for Strategic and Providers. He stated that in his years of auditing, he has applied 42CFR4I3.100 and PRM 2305 "to cost report audits where the costs are used as a basis to reimburse the provider." He further stated that he does not recall making a finding based upon those rules. (Tr., Pt. II, pp. 602)

He testified that the PRM "certainly applies to Medicare. Because Ohio has deemed it in part of the hierarchy of criteria, it applies to Medicaid too." Furthermore, he acknowledged that there is no section

in the PRM which applies only to Medicare or only to Medicaid and there is no wording in the PRM which says that one rule applies to Medicare and one rule applies to Medicaid. (Tr., Pt. II, pp. 484-86)

Mr. Hapchuk admitted he was not familiar with the rules applicable to Ohio's Medicaid cost reports and does not know what is allowable in Ohio cost reports. Moreover, he does not know any provision of the Ohio Revised Code or Ohio Administrative Code that applies to the reporting of Providers Choice and Strategic costs in the cost reports. (Tr., Pt. II, pp. 558,560)

As a preliminary matter, Mr. Hapchuk stated that Medicare rules, including 42 CFR 413.100, do not apply in a prospective payment system (PPS).[18] In an attempt to understand the type of reimbursement system used in Ohio, prior to the hearing, he printed off a one-page document from the internet which listed the various reimbursement systems used in Ohio, using words such as retrospective, semi-prospective, prospective and pricing. There were no definitions for any of these terms and he acknowledged he could have a different definition than that used by Ohio. (Tr., Pt. II, pp. 520, 548-550, 561; State Exhibit 274)

He stated that a Medicare prospective payment system is one in which "payment is not dependent upon what costs they incur, it's dependent upon what type of

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[18] Throughout the hearing different witnesses used the terms "prospective" and "retrospective". At times the witness clarified how he/she used the term. An explanation of how Ohio used the various terms is set forth at pages 15-16 of the Report and Recommendation.

services they perform." Mr. Hapchuk gave the following example to explain the difference between retrospective and prospective:

> Normally cost reimbursement is retrospective, when I said you take the costs, put them on a piece of paper, give it to the government, and then they do something and they determine liability, pay you. Prospective to me is the PPS system whereby ... the government says I'm going to give you a thousand dollars for each appendectomy. . . . [T]he amount of costs incurred by the provider is immaterial because I'm going to pay you on prices.

(Tr., Pt. II, pp. 540, 631)

Since in Ohio, in 2003, the rates were based upon the reported costs incurred, not the type of service performed, Ohio was not under a prospective payment system such as that described by Mr. Hapchuk and used by Medicare. He further explained that in a retrospective system, cost reports are utilized and the provider is required to report reasonable costs. He stated that this system was in place in Ohio in 2003 and that under Medicaid, "states have an option of how they want to reimburse. It appears Ohio had retrospective. They were reimbursing 100 percent of reasonable costs." (Tr., Pt. II, pp. 525-28)

Mr. Hapchuk stated that under the system Ohio had in 2003, the providers were to report their reasonable costs. He further testified that in reporting these costs, 42 CFR 413.100 and PRM 2305 would be applicable. In his auditing experience, he has applied

42 CFR 413.100 and PRM 2305 to cost report audits where the reported costs are used as a basis to reimburse the provider. (Tr., Pt. II, pp. 531, 533, 535-36, 604)

Mr. Hapchuk, however, stated that reporting costs "is one thing and what is going to be reimbursed is another. One is putting a number on a document. The other one is how much cash you are going to actually get." When asked to separate what gets reported and what gets reimbursed, Mr. Hapchuk stated it was "very, very, very difficult to separate them" in this case. (Tr., Pt. II, pp. 534, 535)

He was asked to look at the invoice from Strategic to Carington Park for the Enhanced Services. Mr. Hapchuk stated he had not seen this document or any of the other invoices for these services. He had, however, looked at the promissory notes. Mr. Hapchuk was asked whether the invoice, which stated "Payment due upon receipt of invoice", was a short-term liability. Mr. Hapchuk responded, "I don't think I'm prepared to stipulate to that." He went on to explain:

> Well, when you talk about short-term and long-term liabilities, and everybody keeps talking about one year, and I agree there's a one-year rule, but in my mind, who determines if something is a liability? And I really don't know, to tell you the honest truth. I don't know if this was booked by Carington as a short-term liability; if it was treated as a payable, which meant it never hit the books. What I do know is that eventually both Carington and the other ones thought of it as a long-term promissory

> note .... I'm not sure I understand the rules for it, frankly.

(Tr., Pt. II, pp. 574-75; State Exhibit 59)

Mr. Hapchuk was presented with a scenario in which he might be serving as an auditor and was provided with 1) a contract indicating services rendered between January 1, 2003 and December 31, 2003 and 2) a corresponding invoice for these services, dated December 31, 2003, and stating the invoice is payable upon receipt. He was asked whether the invoice was a short-term liability. He responded that "the reason I don't want to do it is I understand what these data are going to be used for." He further stated that "Carington didn't cause the State to convert over to a PPS system....My whole thing on this is nobody has questioned that these consulting services were true, valid, related to patient care. ... And my feeling is, okay, so you know, if they had kept the cost reimbursement system, I'd probably have a different idea." Mr. Hapchuk then stated that his "judgment is, hey, I don't see any harm here, quite frankly. I don't." (Tr., Pt. II, pp. 579-80)

Then ODM's counsel asked him to look at the Strategic and Providers Choice contracts for services and whether they are reportable in a calendar year 2003 cost report. Mr. Hapchuk replied that he was unable to do so for a Medicaid cost report. (Tr., Pt. II, pp. 590)

He later acknowledged that the invoice for Enhanced Services was due upon receipt, which is less than one year, and the definition of a short-term

liability is a liability that is due in less than one year. He further admitted that according to 42 CFR 413.100, a short-term liability should be liquidated within a year. He was then asked whether the promissory note, which is a negotiable instrument, is liquidating the short-term liability of the invoice. He agreed that the promissory note was liquidating something, that it was liquidating a liability. But he could not say whether the liability was short-term or long-term. (Tr., Pt. II, pp. 593-96)

It is noted that in his written expert report, Mr. Hapchuk wrote: "a short-term liability such as the money due Strategic and Providers was paid in the form of the delivery of 3 year promissory notes...." He also wrote: "Payment of the short-term liabilities due Strategic and Providers Choice was completed when the promissory notes were signed and delivered to those companies." Mr. Hapchuk went on to say that "Since the execution and delivery occurred before December 2004 the short-term liability was timely liquidated." (Respondent Exhibit NNNN, pp. 4, 6, 7)

He opined that, based upon the facts presented to him in this case, the Liquidation of Liabilities Rules does not apply. He stated, however, if Ohio's reimbursement system had not changed, he would have a different opinion. "Under the old system, the State would pay for something, a cost for 2003 when it was actually liquidated. They would have paid for it eventually." (Tr., Pt. [I, pp. 503, 514-15, 517)

Reds Tickets

Terrace View Gardens, Franklin Ridge, East Galbraith Health Care Center, Glen Meadows and Wellington Manor reported on their 2003 cost reports the costs associated with the purchase of 2004 Cincinnati Reds season tickets. State Exhibit 41 is an invoice for season tickets Cincinnati Reds games to Joe Tucker, 2470-1/2 Princeton Pike Rd., Hamilton, Ohio. The tickets were for the 2004 baseball season. There was no evidence as to who Joe Tucker is and/or what, if any, affiliation he has with CHS. These costs were reported in the "employee benefits" accounts.[19] (Tr., Pt. II, p. 146; State Exhibit 268, p. 3; State Exhibit 41)

PRM, CMS Pub. 15-1, section 2105.8 states: "Costs incurred by providers for entertainment, including tickets to sporting or other events, ... are not allowable." Mr. Cummins stated: "The Reds tickets were classified as employee benefits. They were used for the staff of the Cincinnati-based facilities. Carington Health System had a policy that was in writing, and had been established as to what it was going to be used for." No such policy was identified during the hearing. In Respondent Exhibit VV, however, an undated single page document was found, titled "Cincinnati Reds Season Ticket Policy." There was no indication where this document came from; there was no number on the page (other than the exhibit page number) which might indicate that that it came from an employee manual or some other type of

[19] Cost accounts 6530, 7070 and 7520 are employee benefit accounts. (Tr., Pt. II, p. 146)

employee benefit package material. There were no initials indicating that the auditors saw the document during the audit. Therefore, there is no way of knowing when this document was created. When asked at the hearing if there was a continuous string of payments over the years for Reds tickets for employee benefits, Mr. Cummins responded, "I would imagine so." (Tr., Pt. II, pp. 777-78, 780; Respondent Exhibit VV, p. 2)

Ms. Hess stated in the few instances where this has occurred in Ohio, the auditors sought counsel from the State on how to handle a cost of sporting tickets under employee benefits. She said since the rule specifies that the benefit has to be nondiscriminatory, i.e. available to all, Ohio has instructed the auditors that the cost is allowable if documentation is provided as to which employees attended the game. Ms. Hess acknowledged that there is no specific rule that requires the names of employees. She said that although the regulations deny tickets altogether, Ohio gives a little leeway and will allow it as an employee benefit if there is documentation to show that the tickets are available to all employees, not just the owners and their friends. Although Mr. Cummins said the tickets were not used for the benefit of the owners, no documentation or other evidence to support this statement was produced. (Tr., Pt. II, pp. 147-49, 164, 782)

Furthermore, Ms. Hess also testified that employee benefits which are included in a cost report must be conferred during the cost-reporting period. Any benefit purchased or paid for in 2003 and included in the 2003 cost report must be used by the employee during that year. The tickets at issue were purchased in 2003 and

used during 2004. Therefore, if, in fact, the tickets were an employee benefit, they would only be an allowable expense if they were used in 2003. (Tr., Pt. II, pp. Hess, p. 148)

Mr. Cummins was asked if this was a valid basis for disallowance of the cost on the cost report. He responded that if something is reported in the wrong period, if it was reported in 2003 and should have been reported in 2004, the way that matter was resolved was to put the cost "in the more appropriate period." He stated, however, that in this case, because of the legislative change, this cost could not have been "pushed forward." (Tr., Pt. II, pp. 779-80)

Analysis

Audit/Agreed-Upon Procedures

Nursing home Medicaid providers are required to file annual cost reports with the Department. These cost reports, which "capture the costs and expenses incurred [during the year] for providing services to residents within the facility," are used to determine reimbursement for nursing home Medicaid providers. Nursing homes are required to maintain records to support the costs included in the cost reports, including financial, medical and statistical. "In the Medicaid audit setting, a provider must provide supporting documentation that demonstrates that the reported cost was actually incurred, that it is reasonable, allowable and related to patient care." *Meadowwood Nursing Facility v. Ohio Dept. of Job and Family Servs*, (10th Dist. 2005), 2005-Ohio-1263 at ¶19. (Tr., Pt. I, p. 130)

Pursuant to R.C. 5111.27, the Department is authorized to audit cost reports. These audits may be conducted by auditors under contract or ones employed by the Department. If the Department elects to use contract auditors, the contracts shall be entered into by bidding. With respect to the audits in this matter, the Department issued a Request for Proposal and Clifton Gunderson was one of the vendors selected to perform the cost report audits.

Pursuant to Ohio Admin. Code 5101:3-l-27(B)(1), an audit is

> A formal post payment examination made in accordance with generally accepted accounting standards, of a Medicaid provider's records and documentation to determine program compliance, the extent and validity of services paid for under the Medicaid program and to identify any inappropriate payments.

The Department has conducted the audits of cost reports pursuant to Agreed-Upon Procedures since 1999. Respondent, however, contends that Agreed-Upon Procedures used by Clifton Gunderson do not constitute an audit. In support of its position, Respondents point to the testimony of Emily Hess who stated that some procedures for performing an audit are different than those under Agreed-Upon Procedures.

Ms. Hess explained that the use of the term "audit" has different meanings. She stated that under the auditing standards, "which is where the financial-based audits come from, there are specific standards that

have to be applied to those auditing standards." She stated that many judgment calls need to be made, such as control analysis or risk analysis. The primary purpose for financial-based audits is to enable people to look at the financial statements to make a decision on, for example, stock exchange or banks making loans. There are many purposes for an audit of a financial statement. (Tr., Pt. I, p. 523)

Under the auditing standards for governmental entities or entities receiving government funds such as Medicaid, however, there are attest standards. These standards are at a different level than financial based audits because the purpose of the audit of a governmental entity/entity receiving government funds is different. In the audits at issue in this case, the auditors were looking at specific information for a purpose - the impact of the cost report on the rate. Therefore, in these audits the purpose is to ensure that the costs included in a cost report are correct, documented, reasonable and allowable. In a cost report, the auditors are not looking at internal controls, inventory, accounts payable or cash status. (Tr., Pt. I, pp. 523-24)

The Independent Accountant's Report on Applying Agreed-Upon Procedures, "has specific language that is required under AICPA standards for attestation statement engagements compared to the auditing standards." For example, under the attestation standards, no representation can be made as to the sufficiency of the procedures because Clifton Gunderson did not write them, and, therefore, Clifton Gunderson cannot "take ownership of them as a CPA

firm." The report states: "This agreed-upon procedures engagement was performed in accordance with attestation standards established by the American Institute of Certified Public Accountants." (Tr., Pt. I, pp. 523-25; Respondent Exhibit RR, p. 1176)

In advancing its argument that an audit was not performed in this case, Respondent cites two cases, *Medcorp, Inc. v. Ohio Dept. of Job and Family Services* (10th Dist., 2008) 2008-Ohio-464 and *HCMC, Inc. v. Ohio Dept. of Job and Family Services, (10th Dist. 2008)179 Ohio App. 3d 707*, which found proper audits had not been performed. Neither of these cases, however, concern cost report audits and are, therefore, not relevant to the herein matter. The issue in *Medcorp* concerned the use of statistical sampling methodology used by the Department to extrapolate the results of a small sample of claims to a larger sample. The Court in *Medcorp* found that the sampling methodology used by the Department and its application to the audit of Medicaid claims for medical transport was invalid. There is no issue of sampling in the herein case. *HCMC* concerned Medicaid payments on a fee-basis. HCMC, an oxygen supply company, provided services to Medicaid and non-Medicaid patients, billing the patients in different ways and at different rates. Again, the issues in *HCMC* are completely different than those in the herein case.

The issue of cost report audits, however, was specifically addressed by the Tenth District in *St. Francis Home, Inc. v. Ohio Dept. of Job and Family Services (10th Dist. 2006)* 2006-Ohio-6147. The Court stated that "R.C. 5111.27(B) provides that the scope of

an audit conducted is within the discretion of ODJFS." *Id*. at ¶25 Furthermore, the factors set forth in R.C. 5111.27(B) "embody the standards that the audits be conducted in a manner to produce an accurate result and ODJFS utilize auditing procedures that are objectively verifiable." *Id*. at ¶21. Moreover, the Court held that under R.C. 5111.27(B), the Department shall consider accepted auditing standards and even if the auditors did not comply with generally accepted auditing standards the audit is not rendered invalid. *Id*. at ¶23

The audit manual and program for audits of cost reports is to include the following:

(1) Comply with the applicable rules prescribed pursuant to Titles XVIII and XIX;

(2) Consider generally accepted auditing standards prescribed by the American institute of certified public accountants;

(3) Include a written summary as to whether the costs included in the report examined during the audit are allowable and are presented fairly in accordance with generally accepted accounting principle and department rules, and whether, in all material respects, allowable costs are documented, reasonable, and related to patient care;

(4) Are conducted by accounting firms or auditors who, during the period of the auditors' professional engagement or

employment and during the period covered by the cost reports, do not have nor are committed to acquire any direct or indirect financial interest in the ownership, financing, or operation of a nursing facility or intermediate care facility for the mentally retarded in this state;

(5) Are conducted by accounting firms or auditors who, as a condition of the contract or employment, shall not audit any facility that has been a client of the firm or auditor;

(6) Are conducted by auditors who are otherwise independent as determined by the standards of independence established by the American institute of certified public accountants;

(7) Are completed within the time period specified by the department;

(8) Provide to the provider complete written interpretations that explain in detail the application of all relevant contract provisions, regulations, auditing standards, rate formulae, and department policies, with explanations and examples, that are sufficient to permit the provider to calculate with reasonable certainty

> those costs that are allowable and the rate to which the provider's facility is entitled.

R.C. 5111.27(B)

As the court in *St. Francis* stated, "These requirements embody the standards that the audits be conducted in a manner to produce an accurate result and ODJFS utilize auditing procedures that are objectively verifiable." Therefore, if an audit is conducted in such a manner as to produce an accurate result and the procedures used are objectively verifiable, a valid audit is performed. Agreed-Upon Procedures, which the Department has utilized since 1999, set forth the scope and method to be utilized in conducting the cost report audits. The auditors must indicate the steps taken and provide work papers documenting their work to verify their findings. *Id*. at ¶21.

Respondent argues that Clifton Gunderson did not complete the Agreed-Upon Procedures and presents several bases for its contention.

First, Respondent states that "the most fundamental flaw in the procedures performed by Clifton Gunderson is the obvious lack of independence by the auditors." (Post-hearing Brief of Appellant (Phase I) at 9) In support of its argument that Clifton Gunderson lacked independence, Respondent noted that in its response to the RFP, Clifton Gunderson included Mr. Wilkins, former chief of the Department's Bureau of Audit, as a reference. However, since Clifton Gunderson had performed hundreds of cost report

audits for the Department, Mr. Wilkins was familiar with Clifton Gunderson's work and would be an appropriate reference.

The issue of independence is an important factor. Therefore, R.C. 5111.27(B) specifically states that the accounting firm pe1forming the audit 1) shall not audit any facility that has been a client of the firm or auditor and 2) the firm not have direct or indirect financial interest in a nursing facility. These factors concern independence from the entity being audited, not from the Department. Moreover, R.C. 5111.27 authorizes the Department to use its own employees to perform cost report audits. The employees are obviously not independent from the Department.

Respondent also claims that Clifton Gunderson could not be independent because in its response to the RFP, Clifton Gunderson stated that it found a 5:1 return-on-investment ratio for prior audits. Therefore, argues Respondent, "it is difficult to imagine how this auditing firm will perform work truly independently and not driven by the incentive to at least meet this prior ration." (Post-hearing Brief of Appellant (Phase I) at 9-10) Since any disallowance that an auditing firm finds in a cost report audit must be substantiated with documentation, the nursing home is protected from any unsupported finding.

Second, Respondent argues that Clifton Gunderson departed from the Agreed-Upon Procedures outlined in the RFP. After being awarded the contract and prior to commencement of work, Clifton Gunderson requested a slight modification to the cash disbursement testing. This request was granted and approved by Mr. Wilkins

prior to any work being performed under the contract. Although Mr. Wilkins stated that he would have documented that modification in an email or letter, no such document was produced at the hearing. Ms. Hess testified that Clifton Gunderson completed the Agreed-Upon Procedures, which included the modification requested before they commenced work. (Tr., Pt. I, pp. 185-87, 260-61, 497)

Third, Respondent argues that Clifton Gunderson departed from the Agreed-Upon Procedures because it did not obtain a signed representation letter from CHS. The record is clear that Clifton Gunderson attempted to obtain signatures from Wellington Manor, Terrace View Gardens and Glen Meadows, but they refused to provide signatures. (Tr., Pt. I, pp. 582-83, 679-80)

Mr. Cummins testified that the AICPA standards regarding the performance of Agreed-Upon Procedures "specifically state that if the accountant cannot obtain a management representation letter from a responsible party, they are required to withdraw, and there is no exception. They are required to withdraw." In this case, the practitioner is Clifton Gunderson, the responsible party is CHS and the client is the Depaitment. (Tr., Pt. I, pp. 561, 585, 588)

AICPA AT section 201.39 states:

> The responsible party's refusal to provide written representation determined by the practitioner to be appropriate for the engagement constitutes a limitation on the performance of the engagement. In such

circumstances, the practitioner should do one of the following:

a. Disclose in his or her report that inability to obtain representation from the responsible party.
b. Withdraw from the engagement.
c. Change the engagement to another form of engagement.

Furthermore, AT section 601.13 states "If, in an agreed-upon procedures engagement, the practitioner's client is not the responsible party, the practitioner is not required to withdraw but should consider the effects of the responsible party's refusal on the engagement and his or her report." Therefore, Clifton Gunderson was not required to withdraw from the audit. Moreover, Clifton Gunderson notified their client, the Department, that Respondents refused to sign the representation letter. (State Exhibit 20, p. 3)

Fourth, CHS argues that Clifton Gunderson did not complete the engagement. After the exit conference between CHS and Clifton Gunderson, Clifton Gunderson requested additional documentation, some of which was subsequently provided. After reviewing these documents, Clifton Gunderson incorporated the relevant information into the audit results, revised the disallowances, and submitted the Audit Input Document, copy of the proposed cost adjustments and papers, thus completing the audit. (Tr., Pt. I, pp. 311, 316)

Fifth, Respondent contends that the basis upon which disallowances due to related party issues were

made were inadequate. These disallowances were also based upon lack of documentation. Moreover, the issue of appropriateness of individual cost adjustments was to be addressed in Phase II of the hearing. (Tr., Pt. I, pp. 515-16)

Sixth, although Respondents acknowledge that "lack of documentation is a valid criterion for disallowing costs," (Post-hearing Brief of Appellant (Phase I) at 15) they argue that Clifton Gunderson was at fault for failing to contact Bert Cummins about the difficulties in obtaining documentation. The nursing home facility is required to maintain adequate documentation to substantiate its costs. It is incumbent upon the facility being audited to produce the documentation to support the costs included in cost reports. Respondents were given months to collect the information requested by Clifton Gunderson. They failed to do so. They cannot now turn around and say the audit is invalid because the auditor did not have sufficient information to complete the audit.

Seventh, Respondents contend that all proposed adjustments were not discussed with Respondent at the exit conference with Clifton Gunderson. CHS bases its argument upon the fact that the second page of the form documenting the exit interview was not filled in. This second page has three sections: "Proposed Adjustment Areas", "Document agreement and/or disagreement with the proposed adjustments and any pertinent comments below", and "Were work papers given to the provider? If yes, please indicate which work papers." However, David McClellan, CHS' Corporate Controller, signed the first page of the form,

which states: "All of the proposed adjustments known at this time were discussed with the Provider and a copy of the proposed adjustments was given to the Provider." Additionally, CHS was given a list of outstanding documents and records requested but not received. (State Exhibit 9, Terrace View , p. 371)

Finally, Respondent contends that the audit conducted by Clifton Gunderson was inconsistent with others it had conducted and with an audit conducted by another firm, Tichenor & Associates. Respondent argues that, since Clifton Gunderson always performed its engagements in the same manner, the results regarding related party transactions should have been the same. In the audits at issue, however, one of the issues with the related party transactions was a lack of documentation. It is unknown what type of documentation the auditors in the previous audits received from CHS. Respondent also argues that Tichenor conducted an audit of a three-month period which was also included in the period Clifton Gunderson's audit and "made no adjustments for any home office costs associated with Strategic or Provider's Choice." (Tr., Pt. I, p. 319; Post-hearing Brief of Appellant (Phase I) at 18)

As a preliminary matter, it is unknown what documents CHS produced to Tichenor. Furthermore, as the Tenth District responded to a similar argument raised in *Meadowwood* , 2005-Ohio-1263, "the other years are irrelevant here. ODJFS could have mistakenly allowed the expense." *Id*. at ¶29, In other words, prior audits do not bind subsequent audits. As a final matter, it is interesting that CHS is asserting

that Tichenor performed an audit, since the Agreed-Upon Procedures used by Clifton Gunderson were the same as those used by Tichenor. (Tr., Pt. I, pp. 673-74)

Respondent also argues that it did not receive an exit conference. However, the exit conference was held between Respondents and Clifton Gunderson's auditors on June 16, 2003. What Respondents did not get was a final fiscal audit conference, which may be held after a proposed adjudication order is issued. There is no requirement for the Department to hold these conferences.

In conclusion, the Agreed-Upon Procedures performed by Clifton Gunderson in the cost reports at issue herein constitute an audit for purposes of R.C. 5111.27.

Direct Care and Indirect Care Consulting Costs

The parties entered into contracts with Providers and/or Strategic for services for 2003. The Stipulation of the Parties ¶¶ 6 and 7, attached hereto as Attachment C, set forth the relevant contracts. These contracts consisted of two parts: those outlined in the main body of the contract, ("Annual Services") and an attachment to the contract ("Enhanced Services").

In analyzing whether the costs, which were not paid within one year of the end of the cost reporting period, are reasonable and allowable, it is necessary to look at the provisions of the CFR and PRM, specifically 42 CFR 413.100 and PRM 2305 (collectively, "Liquidation of Liabilities rule").

The Federal Register, which provides some guidance in interpreting the CFR, states that 42 CFR 413 codifies the long-standing policy regarding "the timing of payment for accrued costs by requiring timely liquidation of liabilities [to receive payments]. This policy is intended to prevent the outlay of federal trust funds before they are needed to pay the costs of providers' actual expenditures."[20] (60 Fed. Reg. 33129 (June 27, 1995))

Moreover, "[t]he purpose of the regulation [42 CFR 413] is to assure that Medicare recognizes only costs associated with a liability that is timely liquidated through an actual expenditure of funds. GAAP does not offer this assurance for Medicare." In another comment, it states that "in the absence of timely liquidation of the liability, the cost can be claimed in the cost reporting period when the liquidation occurs, that is, when actual expenditure takes place, as currently described in section 2305 of the Provider Reimbursement Manual." (60 Fed. Reg. 33131 (June 27, 1995); State Exhibit 272, p. 6)

Respondents, however, contend that although the CFR and PRM are part of the hierarchy of rules which apply in Ohio in determining appropriate costs in cost reports, these particular provisions of the CFR and PRM do not apply to Medicaid cost reports. Furthermore, Respondents argue that the liability created by the contracts for Enhanced Services and the

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[20] It is noted that this comment addresses Medicare. Ohio, through its hierarchy of authorities, has adopted the CFR and PRM for its Medicaid program.

subsequent invoices for such services are not a short-term liability, and, therefore, 42 CFR 413.100 and PRM 2305 do not apply.

First of all, Respondents argue that 42 CFR 413.100 does not apply in a prospective payment system. The Background section of the Federal Register commenting upon 42 CFR 413.100, states that this section does not apply to Medicare providers under a prospective payment system. 60 Fed. Reg. 33126 (June 27, 1995) Mr. Hapchuk described the Medicare prospective payment system as one in which "payment is not dependent upon what costs they incur, it's dependent upon what type of services they perform." Furthermore, Mr. Cummins stated that under a prospective payment system, nursing homes are reimbursed at a flat rate for each RUG (Resource Utilization Group) category, regardless of the cost to the facility. The flat rate is per service rendered regardless of cost. (Tr., Pt. II, p. 879)

From fiscal year 1994 through fiscal year 2005, Ohio was on a prospective cost-based system. In this system, Ohio reimbursed nursing home facilities based upon their actual reasonable costs, which were used to establish the per diem rate for the next fiscal year. Mr. Hapchuk acknowledged that Ohio's system during this period was not a prospective payment system as used under Medicare. The providers in Ohio were reimbursed based upon costs incurred rather than service provided, thereby distinguishing Ohio's prospective cost-based system from the Medicare prospective payment system. Accordingly, Respondents' argument that 42 CFR 413.100 and PRM 2305 do not

apply to 2003 cost reports based upon the reimbursement system in effect at the time is not well-taken.

Respondents also argue that the Liquidation of Liabilities rule, which addresses short-term liabilities, does not apply to the Enhanced Services contracts because the liability is not short-term.

42 CFR 413.100 addresses special treatment of certain accrued costs. The rule states that "under the accrual basis of accounting, revenue is reported in the period in which it is earned and expenses are reported in the period in which they are incurred." However, for "the accrual of costs for which a provider has not actually expended funds during the current cost reporting period," the rule then sets forth requirements for liquidation of liabilities. If these requirements are not met, the cost is disallowed, generally in the year of accrual, except as specified in another portion of the rule which does not apply to this case.

One type of accrued cost addressed in 42 CFR 413.100 is a short-term liability. Specifically, "a short-term liability, including the current portion of a long-term liability (for example, mortgage interest payments due to be in the current year), must be liquidated within 1 year after the end of the cost reporting period in which the liability is incurred." A short term liability is one that is due and payable within one year of its occurrence. (Tr., Pt. II, pp. 42, 113, 240; 42 CFR 413.100(c)(2)(i)(A))

Respondent contends that the invoices for the Enhanced Services Contracts for services to be

provided in 2003 were not short-term liabilities. In accordance with the terms of the Enhanced Contracts, on December 31, 2003, Strategic and Providers billed the CHS facilities for the entire amount of the Enhanced Services portion of the contract. The invoice stated "payment due upon receipt of invoice." That same day, December 31, 2003, CHS facilities entered into promissory notes with Strategic and Providers for the full amount of these invoices. The promissory notes stated that payments would not commence until mid-2005.

The Department contends that the December 31, 2003 invoices for Enhanced Services, payable on receipt, are short-term liabilities. Respondents argue that the debt for the Enhanced Contract was a long-term debt and the promissory notes liquidated the debt.

The witnesses disagreed on whether the debt was a short-term and long-term liability. Mr. Cummins said the Enhanced Services contracts were long-term. Ms. Hess said they were a short-term liability. Mr. Hapchuk was unable to state whether the Enhanced Services invoices were long-term or short term liabilities. At one point in his testimony, when asked if an Enhanced Service contract was a short-term liability, he did not want to answer that question because he understood "what these data are going to be used for" and then stated that CHS did not cause the legislature to change the reimbursement system. He did state that the promissory note was liquidating a liability, but he could not say whether the liability was short-term or long-term. Although he stated "who

determines when a liability is a liability?" he did acknowledge that the invoice was a liability. When asked when the liability was due, he responded, "Half of the train says due upon receipt, and I don't know eventually it came up it was a long-term promissory note." In his written expert report, however, Mr. Hapchuk wrote: "a short-term liability such as the money due Strategic and Providers was paid in the form of the delivery of 3 year promissory notes...." He also wrote: "Payment of the short-term liabilities due Strategic and Providers Choice was completed when the promissory notes were signed and delivered to those companies." Mr. Hapchuk went on to say that "Since the execution and delivery occurred before December 2004 the short-term liability was timely liquidated." (emphasis added) (Tr., Pt. II, pp. 575, 577-78, 593-96, 913; Respondent Exhibit NNNN 4, 6, 7)

Mr. Fleischer stated that if an invoice is due immediately, it is a short term liability. He was shown a copy of an invoice dated December 31, 2003 from Strategic to Carington Park for Enhanced Services. This invoice stated "Payment Due Upon Receipt of Invoice." Mr. Fleischer testified that it was a short-term liability. (Tr., Pt. II, pp. 242, 278; State Exhibit 59, p. 4)

Respondents, however, argued that the statement on the invoices saying "due upon receipt" is irrelevant and has no meaning. It is merely form over substance and is a statement put on all of Strategic and Providers Choice invoices. On the same date as the invoices, CHS issued promissory notes for the entire amount of the invoice. If the invoices were not due upon receipt,

however, there would be no need to immediately issue the promissory notes.

Accordingly, the December 31, 2003 invoices for Enhanced Services are short-term debts. Having found that the invoices for the Enhanced Services were short-term liabilities, it is necessary to look at the provisions of 42 CFR 143.100 and PRM 2305, which address the liquidation of liabilities of short-term liabilities.

The CFR provision requires that a short-term liability must be liquidated within one year after the end of the cost reporting period in which the liability is incurred. The CFR, however, does not define what the term "liquidate" means. Therefore, according to the hierarchy of authorities, it is necessary to look to the PRM. The Provider Reimbursement Manual, CMS HIM-15-1, section 2305 is consistent with the CFR, but sets forth additional requirements regarding short-term liabilities. In addition to requiring that the short term liability be liquidated within one year after the end of the cost reporting period, the PRM requires:

> Liquidation must be made by check or other negotiable instrument, cash or legal transfer of assets such as stocks, bond, real property, etc. Where liquidation is made by check or other negotiable instrument, these forms of payment must be redeemed through an actual transfer of the provider's assets within the time limits specified in this section. Where the liability (1) is not liquidated within the 1-year time limit, or (2) does not qualify under the exceptions

> specified in §§2305.1 and 2305[21], the cost incurred for the related goods and services is not allowable in the cost reporting period when the liability is incurred, but is allowable in the cost reporting period when the liquidation of the liability occurs. (emphasis and footnote added)

Therefore, it is necessary to determine whether the liability or debt set forth in the invoices for Enhanced Services was (1) liquidated within one year of the end of the cost reporting period and (2) whether that liquidation complied with the requirements set forth in PRM 2305.

Respondents argued that promissory notes are used extensively in commercial transactions. The issue in this case, however, involves more than a commercial transaction or mere payment of a debt and accord and satisfaction. As stated in the Federal Register, the purpose of the Liquidation of Liabilities rule is to ensure that "costs associated with a liability are timely liquidated through an actual expenditure of funds." (emphasis added) Recognizing that this purpose is different than that involved in mere commercial transactions, the Federal Register points out that "GAAP does not offer this assurance." (60 Fed. Reg. 33131 (June 27, 1995)) PRM 2305 sets forth specific criteria to be met in order to liquidate a liability or a debt for purposes of cost reporting.

Pursuant to PRM 2305, liquidation must be made:

1) by check or other negotiable instrument; and

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[21] These exceptions do not apply in this case.

> 2) where liquidation is made by check or other negotiable instrument, these forms of payment must be redeemed through an actual transfer of the provider's assets within one year from the end of the cost reporting period in which the expense was incurred.

If both of these criteria are not met, then the "cost incurred for the related goods and services is not allowable in the cost reporting period when the liability is incurred, but is allowable in the cost reporting period when the liquidation of the liability occurs." Therefore, if both of these criteria were not met, the costs for the Enhanced Services contracts should be disallowed in the 2003 cost report.

Having made payment of the December 31, 2013 invoices for Enhanced Services through promissory notes, which are negotiable instruments, CHS complied with the first portion of the rule. Therefore, pursuant to the wording of PRM 2305, the payment, i.e. the promissory note, must be redeemed through an actual transfer of CHS' assets within one year from the end of the cost reporting period, which was December 31, 2004.

Mr. Fleischer testified that the promissory notes did not transfer assets from CHS to Strategic.[22] Rather, Strategic took the notes in lieu of cash. They did, however, liquidate the liability for purposes of GAAP and reporting financial statements of the company. He said that the promissory note given by Carington to

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[22] These comments applied to all Enhanced Services contracts and promissory notes.

Strategic is an asset of Strategic. It is not an asset of Carington. He said that the amount of the promissory note would show as an asset on Strategic's balance sheet. (Tr., Pt. II, pp. 259-61, 266)

There is a difference, however, between what is reported in a financial statement and what is reported in a cost report. Ms. Hess stated that the provisions of 42CFR 413.100 and PRM 2305 place additional requirements for reporting costs in a cost report that do not exist for reporting on a financial statement. The financial statement is only required to follow GAAP, not the CFR or PRM. (Tr., Pt. II, pp. 963-64)

The Federal Register emphasizes that

> GAAP and Medicare payment policy have different purposes. Unlike GAAP, which is intended to be used to present the financial position of an organization, Medicare policy specifically deals with paying providers for costs incurred in furnishing care to Medicare beneficiaries. For payment purposes, the Medicare Trust Funds should not be required to pay a provider for costs associated with liabilities that are not liquidated timely.

60 Fed. Reg. 33129 (June 27, 1995)

Mr. Fleischer consistently stated that the liability of the invoices for the Enhanced Services were liquidated when the promissory notes were issued. He acknowledged that when Strategic deposited CHS' first payment on the promissory note, however, a transfer of funds occurred. (Tr., Pt. II. Pp. 269-70)

In Medical Rehabilitation Services P.C. v. Bowen, U.S. Dist. Ct., E.D. Michigan, No. 87-CIV-75547-DT, 1989 WL 146308 (Sept. 6, 1989), the Court was faced with a situation in which the provider included the full expense ($61,544) ofa deferred compensation package[23] in its cost report. However, the provider paid $17,330 by check and tendered its creditor a promissory note for the balance. In interpreting the PRM 2305, the Court held that "the issuance of a promissory note is not evidence of a liquidation, unless Plaintiff's assets were actually transferred to its creditor within one year of accrual." *Id*. at *7

Another case in which providers issued promissory notes for compensation deferral is *Professional Rehabilitation Outpatient Services v. Health Care Financing Administration*, U.S. Dist. Ct., S.D. of TX, H-00-2526, 2001 WL 1910296 (December 7, 2001). 42 CFR 413.100(c)(iv) states: "accrued liability related to compensation of owners ... must be liquidated within 75 days after the close of the reporting period in which the liability occurs." Professional Rehabilitation Output Services elected to defer payment of the salaries of four corporate officers and subsequently issued promissory notes to each of the officers, committing to pay on or before December 31, 1998. *Id*. at *3

The compensation costs were denied based on the liquidation of liabilities rule. The reasonableness of the

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[23] 42 CPR 413.100 addresses special treatment of certain accrued costs, including short-term liability, vacation pay and all-inclusive paid days off, sick pay, compensation of owners, nonpaid workers, FICA and other payroll taxes, deferred compensation and self-insurance.

costs was not disputed. In upholding the decision to disallow the costs, the court found that the provider failed to timely liquidate the liability because Professional Rehabilitation did not transfer any assets to pay off the promissory notes within the applicable time period. *Id*. at *6

CHS also failed to transfer assets for the promissory notes for Enhanced Services contracts within the requisite time period, and thus CHS failed to meet the two preconditions to reimbursement of costs related to a short-term liability.

In addition to the issues concerning the Enhanced Services contracts, CHS also had annual contracts in which some payments were not made timely pursuant to 42 CFR 413.l00 and PRM 2305. Under the Annual Contracts, Strategic and/or Providers Choice submitted monthly invoices, payable upon receipt, to the CHS facilities. Most, but not all, of the invoices were paid within one year after the end of the cost reporting period. As set forth in the chart on pages 21-22 of the Report and Recommendation, seven invoices (6 from December 2003 and one from November 2003) from Strategic were not paid until 2005. Furthermore, one provider, East Galbraith, made late payments (i.e. more than one year after the cost reporting period) to Providers Choice for all of the services provided in 2003.

Mr. Fleischer was asked to assume that the check dated April 26, 2005, payable to Strategic Nursing

System, was payment for the November 2003 invoice.[24] He agreed that the costs associated with this invoice would not be reported in a 2003 cost report under the liquidation of liability rule. Since these costs were not liquidated within one year after the end of the cost reporting period, under the provisions of both the CFR and PRM, these costs are not allowable in the cost report. (Tr., Pt. II, pp. 243-44; State Exhibit 58, p. 23)

The amounts attributable to the payments for the Annual Contracts and which were paid after December 31, 2004 are set forth in State Exhibit 268, pp. 1, 2 (attached hereto as Attachment B)

As a final matter, CHS contends that the Liquidation of Liabilities rule should not even apply to the facts in this case because the Ohio legislature changed the type of reimbursement system in FY2006. CHS argues that it would be unable to recuperate its costs if they were not included in the 2003 cost reports.

Both Mr. Fleischer and Mr. Hapchuk testified that their opinions regarding the inapplicability of the Liquidation of Liabilities rule to the facts in this case were greatly influenced by the fact that the reimbursement system changed in July 2005. Mr. Hapchuk stated that if the system had not changed, his opinion would be different. (Tr., Pr. II, pp. 248-50, 301, 579-80)

Whether costs are allowable are determined by the law in effect at the time. Moreover, at the time of filing

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[24] The parties agree that the April 26. 2005 check was payment for the November 2003 invoice.

the 2003 cost reports, CHS did not know that the Medicaid reimbursement system would change in July 2005. A future change in the reimbursement system does not provide justification to ignore the cost reporting laws in effect at the time of filing cost reports.

Interestingly, in August 2004, before CHS made any payments on the promissory notes and before the reimbursement system changed, CHSHO Inc. purchased Strategic for $4.6 million, less than the amount of money CHS owed Strategic for the promissory notes at issue here. Mr. Cummins stated that because of this acquisition, CHS "owed the money to themselves." (Tr., Pt. II, p. 894) The monetary implications of this acquisition are unknown and are not relevant to a determination of whether the Enhanced Services costs are allowable in the 2003 cost reports, but may have an impact on concerns raised by Mr. Fleischer and Mr. Hapchuk. Moreover, the 2003 cost reports were used to set the reimbursement rate for FY 2005, a year before the new system went into effect.

The promissory notes at issue in this case total millions of dollars. It is clear that the first payment on the promissory notes were not made until 2005. Therefore, the first outlay of cash was not made by CSH until the beginning of FY2006. The per diem rate CHS received for FY2005, however, was based upon the 2003 cost reports, which included the amount of the promissory notes at issue in this case. Therefore, the figures used to calculate the per diem rate for 2005 included millions of dollars represented by the

promissory notes. Because of the deferred payment arrangement, however, CHS received Medicaid funds prior to actually expending any assets. It is scenarios such as this, where a provider receives government funds prior to expending the money for services, that 42CFR 413.100 and PRM 2305 were intended to prevent.

Cincinnati Reds Tickets

Based upon PRM 2105.8, the cost for season Cincinnati Reds tickets were disallowed. PRM 2105.8 states:

> Costs incurred by providers for entertainment, including tickets to sporting or other events, alcoholic beverages, golf outings, ski trips, cruises, professional musicians of other entertainers, are not allowable. Costs incurred by providers for purposes of employee morale, specifically, for an annual employee Christmas or holiday party, an annual employee award ceremony or for sponsorship of employee athletic programs (bowling, softball, basketball teams, etc.), are allowable to the extent that they are reasonable.

The rule clearly prohibits the reimbursement of tickets to sporting events. Respondents, however, argue that the season Cincinnati Reds tickets were not used for "entertainment," but were employee benefits, which, if reasonable, should be allowed. (Respondents' Post Phase II Merit Brief at 61) Mr. Cummins testified "if they're used for employee benefits, they're allowable if they are reasonable." (Tr., Pt. II, p. 778)

A close reading of the rule, however, does not say that costs of the prohibited items, such as sporting events, are allowable if reasonable. The rule states that costs incurred for employee morale, "specifically" listing the types of events or activities, are allowable if reasonable. None of the prohibited items are included in the listing of employee morale items, which are very different in character than the prohibited items.

Assuming arguendo that Respondents' interpretation is correct, if a provider wishes such prohibited expense to be considered an employee benefit, it is incumbent upon the provider to produce documentation to support such contention. No assumption can be made, as CHS argues, that merely because the cost of tickets were listed under employee benefits on the cost report and included as employee benefits, they were used by employees, as opposed to owners and their friends. Moreover, the unidentified piece of paper entitled "Cincinnati Reds Season Tickets Policy" and found in Respondent Exhibit VV is undated. There is no way of knowing when this document was created. (Respondents' Post Phase II Merit Brief at 62)

Moreover, employee benefit costs must be conferred during the cost reporting period. That was not the case here. Mr. Cummins acknowledged that if these costs were reported in the wrong period, the matter would be resolved by including them "in the more appropriate period." Again, as with the liquidation of liabilities issue, the change of legislation issue was raised as the reason the appropriate year could not be used. (Tr., P. II, p. 779)

For the above stated reasons, the cost for the 2004 Cincinnati Reds tickets should be disallowed and the corresponding adjustments in State Exhibit 268, p. 3 be adopted.

Notice Issue

The Liquidation of Liabilities rule was not cited in the Notice letters as a basis for disallowances. The basis for the disallowance at issue at that time was insufficient documentation to support the reported costs. Therefore, CHS argues that it did not receive notice that the Department was going to use the liquidation of liabilities rule to disallow costs. Specifically, Respondents state: "The intention to apply this rule was not included in the notices of opportunity for a hearing, nor in the audit reports or reports of final settlement attached to and incorporated in the notice of opportunity for a hearing. " Therefore, Respondents argue, "the liquidation of liabilities rule cannot be applied." (Respondents' Post Phase II Merit Brief at 27-28)

The due process afforded a respondent in an administrative hearing is the right to a reasonable notice of hearing and reasonable opportunity to be heard, including reasonable notice of the subject matter of the hearing. *State ex rel. LTV Steel Co. v. Industrial Comm'n of Ohio* (10th Dist., 1995) 102 Ohio App.3d 100, 103-04 The purpose of the notice requirement in R.C. 119.07 is to enable the respondent to prepare a defense. *Geroc v. Ohio Veterinary Med. Bd.* (8th Dist. 1987), 37 Ohio App.3d 192, 198; *Keaton v. Ohio Dept. of Commerce* (10th Dist. 1981), 2 Ohio App.3d 480,482-83

It was only after discovery in this matter that the Department received the documentation which revealed there was no actual transfer of CHS' assets within one year from the end of the cost reporting period. CHS, however, argues that the two-year (2003 and 2004) Combined Financial Statement of all the CHSHO and its Affiliates disclosed promissory notes paid by CHS to Strategic, and, based upon this, the auditors had sufficient information to make a determination on whether to disallow the costs under the liquidation of liabilities rule.

In advancing its argument, CHS relies upon Note L in the Combined Financial Statement of CHSHO and its Affiliates, stating:

> Carington contracted with Strategic Nursing Systems, Inc. (Strategic), to provide direct care consulting services....Additionally, at December 31, 2003 Carington owed Strategic $3,420,131, which was included in accounts payable–trade and accrued liabilities. At December 31, 2003, Carington also owed Strategic $12,082,000 of trade accounts payable that both parties agreed were not due within the next twelve months. This amount was classified as an other long-term obligation.

(Respondent Exhibit MMMM, p. 218)

Note A of the Combined Financial Statement of CHSHO and its Affiliates clarifies that "Carington" refers to CHSHO' Affiliates, stating: "The combined financial statements present the financial position, results of operations and cash flows of CHSHO, Inc.,

and Affiliates (Carington). The financial statements include the accounts of 21 affiliated Ohio corporations that operate under common management and are commonly owned. The corporate affiliates ... operate 35 long-term care facilities." Therefore, in Note L, "Caringtон" refers to 35 long-term care facilities. There is nothing in Note L which identifies which of the 35 facilities have promissory notes. Moreover, Ms. Hess stated that in order to determine which facility had the promissory notes it would be necessary to see the promissory notes prior to making a finding of disallowance of a cost in a cost report. (Tr., Pt. II, p. 986; Respondent Exhibit MMMM, p. 206)

During the audit, the auditors did not receive invoices for the Enhanced Services costs, promissory notes for the Enhance Services costs, or cancelled checks showing payments on the promissory notes. Without this information, the auditors would be unable to make a finding of failure to timely liquidate under PRM 2305. Ms. Hess testified that had they been given those documents, they "would have eliminated the cost based upon the Liquidation of Liability Rule which is Publication 15-1, Section 2305." (Tr., Pt. II, pp. 966-67)

It was only during the discovery stage of the administrative proceeding that the Department received documentation of these costs at issue on the Enhanced Services contracts.[25] The parties stipulated

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[25] It is noted that during the discove1y phase of this case, the Department received additional documentation on other allowances, which it reviewed and gave CHS credit, by removing some disallowances.

that, based upon documents received in the discovery process, the Department's "basis for the proposed disallowance of the costs reported in 6210 and 7215 is that the costs were not timely liquidated as provided by the provisions of 42 CFR §413.100 ... and the provisions of Pub. 15-1 §2305(A), §2305.1 and §2305.2." (Stipulation of the Parties, ¶ 8)

As stated in *Geroc* and *Keaton*, the purpose of the notice requirement in R.C. 119.07 is to enable respondent to prepare a defense. In this case, CHS knew the basis upon which the Department was proceeding and had time to thoroughly prepare its defense, including engaging experts and calling witnesses to address the liquidation of liabilities issues.

Respondent cites *Minges v. Ohio Dept. of Agriculture*, 213-Ohio-1808 (10th Dist. May 2, 2013) in support of its position that it did not receive proper notice. In that case, however, the Ohio Department of Agriculture (ODA) charged respondent with a rule that required ODA to prove a particular behavior. ODA, however, did not present evidence on this behavior and, in its closing argument, relied upon a rule not cited in the notice letter as the basis of its case. Therefore, respondent did not have any opportunity to prepare a defense.

In this case, CHS had ample opportunity to prepare and suffered no prejudice from the fact that the Notice Letter did not include notice of the disallowance under the liquidation of liabilities rule. See *Diso v. Dept. of Commerce*, 2012-Ohio-4672, ¶¶ 72, 73 (5th Dist. October 8, 2010) (finding respondent failed to show he was prejudiced; he had time to prepare his defense).

Moreover, to accept CHS' notice argument would encourage providers to fail to provide sufficient documentation during an audit, then produce the missing documentation during discovery and then require the Department to issue another notice of opportunity letter, starting the process all over again from the beginning.

Prior Use of Liquidation of Liability Rule

CHS argues that the liquidation of liabilities rule has never been used or interpreted in the manner the Department is doing in this case, and, therefore, the Department is precluded from using it in this case. CHS relies upon the testimony of Mr. Fleischer, who stated that, in his experience, he had not seen the rule applied in this manner. From this statement, CHS jumps to the conclusion that it has never been applied in this manner. (Respondents' Post Phase II Merit Brief at 46) The record in this case does not establish this fact one way or another.

Although CHS contends that the Department never applied the rule, it then argues that the Department has changed its application of the rule. CHS cites to *Cove Associates Joint Venture v. Sebelius*, 848 F. Supp. 2d 13 (D.D.C. 2012) to argue that a new interpretation of a rule cannot be applied to past practice. The court, however, required that the providers must prove they relied upon a prior interpretation of a rule. In this case, there is no evidence of a contrary prior interpretation or evidence that CHS relied upon a contrary interpretation.

CHS also raises the argument that the auditors are prohibited from applying the PRM 2305 as it relates to this case because it contends that the audit manual only referenced a liquidation of an owner-administrator compensation, not other types of liquidation of liabilities cited in 42CFR 413.100. During the hearing Mr. Cummins was asked to identify Respondent Exhibit QQQQ, which he identified as six selected pages from the audit manual that was in Clifton Gunderson's file. He said he went through the audit manual looking for references to liquidation of liabilities and this was the only reference he found. By including only one aspect of the rule, CHS argues, all other aspects or portions of the rule are excluded, under the *expressio unius* principle ("the expression of one thing is the exclusion of another"). (Tr., Pt. II, pp. 708-10)

Ms. Hess, however, stated that Respondent QQQQ was not part of the audit manual. It was pait of a more comprehensive document, identified as State Exhibit 280, which was a listing of the most common adjustments made in audits. Moreover, she testified that the audit paragraphs listed in State Exhibit 280 are not an exclusive list and that the auditors would make adjustments for reasons other than those listed in State Exhibit 280. (Tr., Pt. II, pp. 948-50)

Furthermore, the auditors are required to apply all the laws according to the hierarchy set forth in Ohio Admin. Code 5101:3-3-01(A).

<u>Other Audits not at Issue In This Case</u>

CHS also argues that there were other audits performed of other facilities in the CHSHO organization and no disallowance was made using the liquidation of liabilities in the manner it is being used in this case. A determination of whether a cost was allowable would depend, in part, upon the facts and documentation in each case.

One audit raised by Respondent in support of its position is that of East Galbraith, which covered the period of June 29, 2003- September 30, 2003. The Enhanced Service agreements and corresponding promissory notes, however, were not entered into until December 31, 2003. (Stipulation of the Parties, ¶7E) Furthermore, there is no evidence as to the documentation reviewed by the auditors in the other facilities.

Unpaid Days

Respondent contends that the hearing examiner improperly refused to consider evidence on unpaid days, including the admissibility of Respondent Exhibit 0000, which was therefore proffered. This matter was ruled upon in a March 15, 2013 Journal Entry granting the Department's Motion in Limine to exclusion evidence of unpaid patient days for room and board and unpaid claims for services.

Matters that are subject to R.C. Chapter 119 hearings are expressly limited to those matters authorized by statute. R.C. 5111.06 authorizes Chapter 119 hearings as a forum for providers to challenge matters included in final fiscal audits. The statutory/regulatory scheme for final fiscal audits

addresses the examination of payments by the Department, whether such payments were appropriate, and, if a determination of an overpayment is made, the requirements of notice to the provider and the provision of appeal rights under R.C. Chapter 119. The final fiscal audit is the end result of an audit, which was authorized by R.C. 5111.27, to determine whether the provider must refund an overpayment to the Department. Under this statutory/regulatory scheme, non-payment or unpaid claims are not subject to R.C. Chapter 119 proceedings. Unpaid days/claims which CHS wanted to adjudicate, are by definition not overpayments. Therefore, adjudication of claims for unpaid days and unpaid claims are not at issue in this administrative hearing.

Findings of Fact

To the extent any findings of fact constitute conclusions of law, they are offered as such.

1. The Respondents in this matter are: CHS-Glenwell, Inc. [Glen Meadows (provider number 2429330)]; CHS-Ohio Valley, Inc. [Terrace View Gardens (provider number 2339384)]; CHS-Glenwell, Inc. [Wellington Manor (provider number 2429321)]; CHS Miami Valley; Inc. [Vandalia Park (provider number 2339624)]; CHS-Miami Valley, Inc. [Franklin Ridge (provider number 2339688)]; CHS-Greater Cincinnati, Inc. [East Galbraith Health Care Center (provider number 2399033)]; and CHS-Lake Erie, Inc. [Carington Park (provider number 2339268)]. Respondents operate long-term care

facilities, providing room, board and related nursing services to persons eligible for benefits under Ohio's Medicaid program. At the time at issue, ODJFS administered the Medicaid program pursuant to R.C. Chapter 5111 and Title XIX of the Social Security Act.

2. Initially, the cases involved in this matter were split between two hearing examiners. Originally, the above referenced hearing examiner was assigned CHS-Glenwell, Inc. Docket Nos. 09LTC17, 09LTC18, 09LTC19, CHS-Hamilton County, Inc. Docket Nos. 09LTC30, 09LTC31, 09LTC32, 09LTC33,[26] and Carington Health Systems Docket Nos. 09LTC24, 09LTC25[27]. Thereafter, the following cases were transferred to the above referenced hearing examiner and the parties agreed to consolidate the cases: CHS-Miami Valley, Inc. Docket Nos. 09LTC13, 09LTC14, 09LTCl5, 09LTCl6, 09LTC34, 09LTC35, 09LTC36, 09LTC37, CHS-Greater Cincinnati, Inc. Docket Nos. 09LTC20,

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[26] During the hearing, the parties agreed that the correct name for CHS-Hamilton County, Inc. is CHS-Ohio Valley, Inc. and that the caption of the case be amended to reflect this change. They noted that throughout the proceedings the correct Provider No. was used for the entities. (Tr., Pt. II, pp. 23-4)

[27] During the hearing, the parties agreed that the correct name for CHS-Carington Health Systems is CHS-Glenwell, Inc. and that the caption of the case be amended to reflect this change. They noted that throughout the proceedings the documents the correct Provider No. was used for the entities. (Tr., Pt. n, pp. 23-24)

09LTC21, 09LTC22, 09LTC23, and CHS-Lake Erie, Inc. Docket Nos. 09LTC26, 09LTC27, 09LTC28, 09LTC29.

3. Prior to the consolidation, there were three days of hearings in the CHS-Glenwell, Inc. Docket Nos. 09LTC17, 09LTC18, 09LTC19, CHS-Hamilton County, Inc. Docket Nos. 09LTC30, 09LTC31, 09LTC32, 09LTC33, and Carington Health Systems Docket Nos. 09LTC24, 09LTC25 cases to address Respondents' challenge that the Department had not conducted audits. After consolidation, the parties agreed that the determination of whether an audit was conducted would apply to all the cases in consolidated case.

4. The Medicaid cost reports at issue in this matter are: 1) the calendar year 2003 Medicaid cost reports filed by Carington Park, Terrace View Gardens, Vandalia Park, and Franklin Ridge; 2) the six-month cost report covering July 1, 2003, to December 31, 2003, filed by East Galbraith Health Care Center; and 3) the three-month cost reports covering December 1, 2003, to February 29, 2004, filed by Glen Meadows and Wellington Manor. The cost reports are collective referred to as "2003 cost reports."

5. In order to conduct an audit of a cost report, the person(s) conducting the audit reviews records and documents to ensure that the amounts reported in a provider's annual cost

report are reported accurately, are allowable, documented, related to patient care and reasonable. Each cost in a cost report should be verifiable through documentation.

6. ODJFS issued a Request for Proposal (RFP) seeking independent professional auditors to audit the 2003 Cost Reports in accordance with Agreed-Upon Procedures. One of the firms selected was Clifton Gunderson, which has performed cost report audits since the Medicaid program began in the mid-1960's and has performed them for the Ohio Medicaid program pursuant to Agreed-Upon Procedures since 1999.

7. Clifton Gunderson contacted CHS on March 1, 2006, over three months prior to the site visit scheduled for the week of June 12, 2006 requesting the information listed on the attached letter by April 7, 2006. The attachment listed 32 categories for items to be produced and indicated the specific accounts in the cost report to be audited. Ms. Hess stated that CHS only produced documents responsive to one of the requests. Prior to the site visit a second request was made for the general ledgers.

8. On the last day of the field work, an exit conference was held and signed off by three Clifton Gunderson staff and David McClellan, the Corporate Controller for CHS at the time. The signed form states: "All of the proposed adjustments *known at this time*

were discussed with the Provider and a copy of the proposed adjustments was given to the Provider."

9. At the exit conference after the audit, Clifton Gunderson asked CHS to sign the representation letter, which is part of the Agreed-Upon Procedures. CHS refused to do so.

10. Section 600 of the AICPA requires a representation letter, which is usually signed on the last day of field work. This letter is obtained from the entity being audited, in this case, Respondents.

11. When Clifton Gunderson informed the Department of CHS' refusal to sign the letter, Clifton Gunderson was instructed to proceed with the audit as usual.

12. At the exit conference Clifton Gunderson gave CHS a list of still outstanding documents, which was very similar to the list sent in March 2006. This list included, among other things, invoices, canceled checks and contracts, which would substantiate documentation for reported costs. The letter stated that if the items were not received by Clifton Gunderson by June 30, 2006, Clifton Gunderson would make the required adjustments in its report to the Department. CHS provided some documentation for expenses prior to the deadline and Clifton Gunderson incorporated that information

prior to issuing the proposed cost adjustment letter, which was sent to CHS along with supporting work papers of those adjustments. CHS was given seven days to respond to the report; otherwise, the finalized report would be sent to the Department. CHS did not respond and the draft adjustments were finalized to the Department. The Department received the Audit Input Document, copy of the proposed cost adjustments and papers to support Clifton Gunderson's proposed cost adjustments.

13. After receiving the finalized report from Clifton Gunderson, the Department performed a high level review for accepting the actual audit from Clifton Gunderson to ensure that what had been done was adequately documented in the working papers, and that the adjustments tied back to those working papers that were submitted.

14. The procedures for audits, starting with the RFP, the contractor's work and the Department's process after receiving deliverables from the contract auditor have been the same since 1999. The Agreed-Upon Procedures have been modified periodically since 1999.

15. Clifton Gunderson followed the Agreed-Upon Procedures as prescribed in the RFP and the slight modifications made prior to

commencement of the engagement and conducted a proper audit.

16. A final fiscal audit conference or exit conference may be conducted by the Department's Bureau of Audit "to try and resolve potential findings identified by the Department with the providers." This final fiscal audit conference, which is different than the exit conference held between Clifton Gunderson and CHS immediately after the on-site field work was completed in June 2003, is not mandatory.

17. In this case, Respondents requested final fiscal audit conferences. The Department, however, elected to issue Proposed Adjudication Orders, affording Respondents an opportunity to request a hearing under R.C. Chapter 119.

18. The 2003 cost reports at issue in this matter were used to set the per diem rates for fiscal years 2005 and 2006.

19. The Department audited the patient days and patient liability for: 1) Carington Park, Terrace View Gardens, Vandalia Park, Franklin Ridge, East Galbraith Health Care Center for fiscal years 2003, 2004, 2005, and 2006; 2) Glen Meadows for fiscal years 2004, 2005, and 2006; and 3) Wellington Manor for fiscal years 2005 and 2006.

20. The days audits at issue herein were performed in the same manner as the audit

at issue in *Meadowbrook Care Center v. Ohio Dept. of Job and Family Services* (10th Dist. 2007), 2007-Ohio-6534.

21. After performing the patient day/patient liability audits, ODJFS issued Combined Proposed Adjudication Orders (CPAO) for each open audit period for each of the Respondents. Each CPAO contained Reports of Examination, detailing the "calculation leading to the amount determined to be owed." Respondents each timely requested an exit conference. Thereafter, ODJFS re-issued CPAO's for each facility for each open audit period, providing Respondents the opportunity to request a R.C. Chapter 119 hearing. Each Respondent timely requested a R. C. Chapter 119 administrative hearing.

22. Attachment D attached hereto and incorporated herein reflect the revised patient days and patient liability adjustments. Although Respondent's counsel objected to the adjustments in the Reports of Examination and did not stipulate to the amounts, no evidence was presented to rebut the Department's prime facie evidence with respect to patient days and patient liability adjustments. The findings as set forth in Attachment D attached hereto are adopted as a Finding of Fact.

23. Based upon audits on cost reports performed at issue herein, ODJFS issued Notices of Opportunity for Hearing to the facilities for

each of the audits and each Respondent timely filed a request for a R. C. Chapter 119 hearing in the above-referenced matters.

24. Notwithstanding the contents of any initial or any amended Audit Report in these proceedings, the parties have agreed to the Proposed Cost Adjustments set forth in State Exhibit 267a, which is Attachment A, attached hereto and incorporated herein as a Finding of Fact.

25. The parties have stipulated that there were only two issues related to the cost report audit disallowances at issue in this hearing: 1) the Strategic Nursing Services consulting costs (reported by all seven facilities in cost account 6210) and the Providers Choice Administrative Services consulting costs (reported by Carington Park, Terrace View Gardens, Franklin Ridge, Vandalia Park, and East Galbraith Health Care Center in cost account 7215); and 2) the Cincinnati Reds tickets costs reported by Terrace View Gardens, Franklin Ridge, Glen Meadows, and Wellington Manor in cost accounts 6530, 7070, and 7520 and reported by East Galbraith in cost accounts 7070 and 7520.

26. The Proposed Cost Adjustments on State's Exhibit 268 are the sole and only remaining cost report audit adjustment issues. Although the parties agree as to amounts set forth in State Exhibit 268, they disagree as to whether those costs should have been

included in the first place. Stipulations of the Parties, no. 5 These adjustments were made for direct-care consulting costs, found at State Exhibit 268, p. 1, indirect care consulting costs, found at State Exhibit 268, p. 2 and Cincinnati Reds tickets, found at State Exhibit 268, p. 3.

27. Cost reports are the mechanism by which nursing home facilities report their operating costs to the state.

28. Between 1994 and July 1, 2005, Ohio used a prospective cost based payment system, in which a per diem rate was established for each facility based upon the facilities' reasonable costs.

29. Under the Medicare prospective payment system the costs incurred are irrelevant. Reimbursement under the Medicare prospective payment system is dependent upon the type of service performed; the provider is reimbursed a set amount for a set service, regardless of cost.

30. Ohio's prospective cost based system is different than the prospective payment system under Medicare.

31. In 2005, the Ohio legislature passed laws which changed the reimbursement system from the cost-based prospective reimbursement system to a price-based prospective system. During the transition period, the rates in FY 2006 were the same

as those in FY 2005. In FY 2007, the new rates under the price-based prospective system went into effect. Under the price-based prospective system, the State pays "similarly-situated homes the same price subject to case mix adjustments." Rather than looking at the facility's costs, the State looks at "the peer group experience to establish the rate components," while still starting with a calendar year cost report and applying an 18-month inflation factor.

32. CHS– Lake Erie, Inc. d.b.a. Carington Park, provider number 2339268, entered into an agreement with Strategic Nursing Systems, Inc., at State's Exhibit 57. The costs associated with this consulting agreement were reported in account 6210. Strategic Nursing Systems, Inc. invoiced Carington Park monthly for the consulting fees and Carington Park paid each invoice by check as shown in State's Exhibit 58. The consulting agreement (State's Exhibit 57) contained an Attachment A for Enhanced Services, with an additional consulting fee that was due on December 31, 2003, that was invoiced by Strategic Nursing Services as shown by State's Exhibit 59. Carington Park issued an installment promissory note for the December 31, 2003 for the Enhanced Services invoice, State's Exhibit 60. The payments of the installment promissory note were per the note's terms and were by checks at State's Exhibit 61.

33. CHS – Hamilton County, Inc. d.b.a. Terrace View Gardens, provider number 2339384, entered into an agreement with Strategic Nursing Systems, Inc. at State's Exhibit 92. The costs associated with this consulting agreement were reported in account 6210. Strategic Nursing Systems, Inc. invoiced Terrace View Gardens monthly for the consulting fees and Terrace View Gardens paid each invoice by check as shown in State's Exhibit 93. The consulting agreement (State's Exhibit 92) contained an Attachment A for Enhanced Services, with an additional consulting fee that was due on December 31, 2003, that was invoiced by Strategic Nursing Services as shown by State's Exhibit 94. Terrace View Gardens issued an installment promissory note for the December 31, 2003 Enhanced Services invoice, State's Exhibit 95. The payments of the installment promissory note were per the note's terms and were by checks at State's Exhibit 96.

34. CHS - Miami Valley, Inc. d.b.a. Franklin Ridge, provider number 2339688, entered into an agreement with Strategic Nursing Systems, Inc. at State's Exhibit 119. The costs associated with this consulting agreement were reported in account 6210. Strategic Nursing Systems, Inc. invoiced Franklin Ridge monthly for the consulting fees and Franklin Ridge paid each invoice by check as shown in State's Exhibit 120. The consulting agreement (State's Exhibit 119)

contained an Attachment A for Enhanced Services, with an additional consulting fee that was due on December 31, 2003, that was invoiced by Strategic Nursing Services as shown by State's Exhibit 121. Franklin Ridge issued an installment promissory note for the December 31, 2003 Enhanced Services invoice, State's Exhibit 122. The payments of the installment promissory note were per the note's terms and were by checks at State's Exhibit 123.

35. CHS – Miami Valley, Inc. d.b.a. Vandalia Park, provider number 2339624, entered into an agreement with Strategic Nursing Systems, Inc. at State's Exhibit 154. The costs associated with this consulting agreement were reported in account 6210. Strategic Nursing Systems, Inc. invoiced Vandalia Park monthly for the consulting fees and Vandalia Park paid each invoice by check as shown in State's Exhibit 155.

36. CHS – Greater Cincinnati, Inc., d.b.a. East Galbraith Health Care Center, provider number 2399033, entered into an agreement with Strategic Nursing Systems, Inc. at State's Exhibit 181. The costs associated with this consulting agreement were reported in account 6210. Strategic Nursing Systems, Inc. invoiced East Galbraith monthly for the consulting fees and East Galbraith paid each invoice by check as shown in State's Exhibit 182. The consulting agreement (State's

Exhibit 181) contained an Attachment A for Enhanced Services, with an additional consulting fee that was due on December 31, 2003, that was invoiced by Strategic Nursing Services as shown by State's Exhibit 183. East Galbraith issued an installment promissory note for the December 31, 2003 Attachment A Enhanced Services invoice, State's Exhibit 184. The payments of the installment promissory note were per the note's terms and were by checks at State's Exhibit 185. The consulting agreement (State's Exhibit 181) also contained an Attachment B for Enhanced Services, with an additional consulting fee that was due on December 31, 2003, that was invoiced by Strategic Nursing Services as shown by State's Exhibit 186. East Galbraith issued an installment promissory note for the December 31, 2003, Attachment B Enhanced Services invoice, State's Exhibit 187. The payments of the installment promissory note were per the note's terms and were by checks at State's Exhibit 188.

37. CHS - Lake Erie, Inc. d.b.a. Carington Park, provider number 2339268, entered into an agreement with Providers Choice Administrative Services, Inc., at State's Exhibit 63. The costs associated with this consulting agreement were reported in account 7215. Providers Choice Administrative Services, Inc. invoiced Carington Park monthly fat the consulting

fees and Carington Park paid each invoice by check as shown in State's Exhibit 64. The consulting agreement (State's Exhibit 63) contained an Attachment A for Enhanced Services, with an additional consulting fee that was due on December 31, 2003. Carington Park issued an installment promissory note for the December 31, 2003 Enhanced Services fee, State's Exhibit 65. The payments of the installment promissory note were per the note's terms and were by checks at State's Exhibit 66.

38. CHS – Hamilton County, Inc. d.b.a. Terrace View Gardens, provider number 2339384, entered into an agreement with Providers Choice Administrative Services, Inc., at State's Exhibit 98. The costs associated with this consulting agreement were reported in account 7215. Providers Choice Administrative Services, Inc. invoiced Terrace View Gardens monthly for the consulting fees and Terrace View Gardens paid each invoice by check as shown in State's Exhibit 99. The consulting agreement (State's Exhibit 98) contained an Attachment A for Enhanced Services, with an additional consulting fee that was due on December 31, 2003. Terrace View Gardens issued an installment promissory note for the December 31, 2003, Enhanced Services fee, at State's Exhibit 100. The payments of the installment promissory note were per the

note's terms and were by checks at State's Exhibit 101.

39. CHS - Miami Valley, Inc. d.b.a. Franklin Ridge, provider number 2339688, entered into an agreement with Providers Choice Administrative Services, Inc., at State's Exhibit 125. The costs associated with this consulting agreement were reported in account 7215. Providers Choice Administrative Services, Inc. invoiced Franklin Ridge monthly for the consulting fees and Franklin Ridge paid each invoice by check as shown in State's Exhibit 126. The consulting agreement (State's Exhibit 125) contained an Attachment A for Enhanced Services, with an additional consulting fee that was due on December 31, 2003. Franklin Ridge issued an installment promissory note for the December 31, 2003, Enhanced Services fee, at State's Exhibit 127. The payments of the installment promissory note were per the note's terms and were by checks at State's Exhibit 128.

40. Miami Valley, Inc. d.b.a. Vandalia Park, provider number 2339624, entered into an agreement with Providers Choice Administrative Services, Inc., at State's Exhibit 157. The costs associated with this consulting agreement were reported in account 7215. Providers Choice Administrative Services, Inc. invoiced Vandalia Park monthly for the consulting

fees and Vandalia Park paid each invoice by check as shown in State's Exhibit 158. The consulting agreement (State's Exhibit 157) contained an Attachment A for Enhanced Services, with an additional consulting fee that was due on December 31, 2003. Vandalia Park issued an installment promissory note for the December 31, 2003, Enhanced Services fee, at State's Exhibit 159. The payments of the installment promissory note were per the note's terms and were by checks at State's Exhibit 160.

41. CHS - Greater Cincinnati, Inc., d.b.a. East Galbraith Health Care Center, provider number 2399033, entered into an agreement with Providers Choice Administrative Services, Inc., at State's Exhibit 190. The costs associated with this consulting agreement were reported in account 7215. Providers Choice Administrative Services, Inc. invoiced East Galbraith monthly for the consulting fees and East Galbraith paid each invoice by check as shown in State's Exhibit 191. The consulting agreement (State's Exhibit 190) contained an Attachment A for Enhanced Services, with an additional consulting fee that was due on December 31, 2003. East Galbraith issued an installment promissory note for the December 31, 2003, Enhanced Services fee, at State's Exhibit 192. The payments of the installment promissory note were per the note's terms and were by checks at State's Exhibit 193.

42. The Annual Services were billed monthly and the invoice specified that payment was due upon receipt. Terrace View Gardens, Franklin Ridge, Vandalia Park, Glen Meadows, and Wellington Manor paid the Strategic Annual Services December 2003 invoices by checks dated March 2005. Carington Park paid the Strategic Annual Services November 2003 invoice by check dated March 2005 and the Strategic Annual Services December 2003 invoice by check dated April 2005.

43. During the cost reporting period at issue herein, Wellington Manor and Glen Meadows had Annual Services contracts with Strategic. Both facilities reported Strategic costs in cost account 6210 on their three-month cost reports covering December 2003 through February 2004.

44. Glen Meadows and Wellington Manor did not produce canceled checks for the Strategic Annual Services January 2004 and February 2004 invoices.

45. Starting in January 2005 and ending in December 2006, East Galbraith Health Care Center paid the Providers Choice Annual Services invoices issued monthly from July 1, 2003 to December 31, 2003.

46. Glen Meadows and Wellington Manor did not provide the auditors with sufficient documentation to support the Strategic

Annual Services costs they reported in the 2003 cost reports.

47. On December 31, 2003, the facilities issued invoices for the Enhanced Services contracts for 2003. The invoices stated: "Payment due upon receipt of invoice."

48. On December 31, 2003, CHS issued installment promissory notes for each of the December 31, 2003 invoices for Enhanced Services.

49. The December 31, 2003, promissory notes that Respondents issued did not require payment to begin until 2005. The parties have stipulated that the Respondents paid the December 31, 2003, promissory notes according to the notes' terms. None of the payments on the promissory notes were made within one year of the end of the relevant cost-reporting periods.

50. A promissory note is a negotiable instrument.

51. All Respondents reported Strategic consulting costs (Annual Services and Enhanced Services) on the 2003 cost reports in cost account 6210. All Respondents reported Providers Choice consulting costs (Annual Services and Enhanced Services) on the 2003 cost reports in cost account 7215.

52. ODJFS' basis for the proposed disallowance of the costs reported in 6210 and 7215 is that

the costs were not timely liquidated as provided by the provisions of 42 CFR §413.100 (Generally described as the "Liquidation of Liabilities Rule") and the provisions of Pub. 15-1 §2305(A), §2305.1 and §2305.2.

53. In the initial release of CHS' audits by the Department there was no application of the Liquidation of Liabilities rule proposed, referenced or cited. Many of the disallowances were based upon insufficient documentation. Upon receipt of documentation, including the invoices, promissory notes and checks involving the Enhanced Services contracts, the Department made disallowances based upon the Liquidation of Liabilities rule.

54. Mr. Fleischer and Mr. Hapchuk stated that the problem with applying the Liquidation of Liabilities rule in this case is that the Ohio legislature changed the law on how the reimbursement rate would be established.

55. Terrace View Gardens, Franklin Ridge, East Galbraith Health Care Center, Glen Meadows and Wellington Manor reported on their 2003 cost reports the costs associated with the purchase of 2004 Cincinnati Reds season tickets. The invoice for these tickets was issued to Joe Tucker. There was no evidence as to who Joe Tucker is and/or what, if any, affiliation he has with CHS. These costs were reported in the "employee

benefits" accounts. No documentation was presented to show how the tickets were distributed or who used the tickets.

Conclusions of Law

To the extent any conclusion of law constitutes a finding of fact, they are offered as such.

1. All statutory procedural requirements have been complied with and this matter is properly before the Department.

2. Medicaid nursing home providers are required to file annual cost reports, which capture the costs and expenses incurred during the year for providing services to residents within the facility. Nursing homes are required to maintain records to support the costs included in the cost reports, including financial, medical and statistical. "In the Medicaid audit setting, a provider must provide supporting documentation that demonstrates that the reported cost was actually incurred, that it is reasonable, allowable and related to patient care." *Meadowwood Nursing Facility v. Ohio Dept. of Job and Family Servs*, (10th Dist. 2005), 2005-Ohio-1263 at ¶19.

3. Pursuant to R.C. 5111.27, the Department is authorized to audit cost reports and the scope of the audit is within the discretion of the Department.

4. If a cost report audit is conducted in such a manner as to produce an accurate result and ther procedures are objectively verifiable, a valid audit is performed. *St. Francis Home Inc. v. Ohio Dept. of Job and Family Services* (10th Dist. 2006) 2006-Ohio-6147.

5. The Department conducted audits of Respondents' 2003 cost reports pursuant to R.C. 5111.27 (eff. 3/30/2006) (renumbered as R.C. 5165.108 effective 9/29/2013) and Ohio Adm. Code 5101:3-3-21 (eff. 7/04/2002), and the Department issued audit reports related to those audits.

6. Clifton Gunderson completed the Agreed-Upon Procedures, which set forth the scope and method to be utilized in conducting the 2003 cost reports audits.

7. Clifton Gunderson completed the engagement, conducted an exit interview with CHS and discussed all the proposed adjustments with CHS, as evidenced by the signature of CHS' Corporate Controller, who signed verifying that fact.

8. The audits, using Agreed-Upon Procedures, which Clifton Gunderson performed on CHS' 2003 cost reports was conducted in such a manner as to produce accurate results and the procedures were objectively verifiable. Therefore, Clifton Gunderson conducted a valid audit.

9. The due process afforded a respondent in an administrative hearing is the right to a reasonable notice of hearing and reasonable opportunity to be heard, including reasonable notice of the subject matter of the hearing. *State ex rel. LTV Steel Co. v. Industrial Comm'n of Ohio* (10th Dist., 1995) 102 Ohio App.3d 100, 103-04. The purpose of the notice requirement in R.C. 119.07 is to enable the respondent to prepare a defense. *Geroc v. Ohio Veterinary Med. Bd.* (8th Dist. 1987), 37 Ohio App.3d 192, 198; *Keaton v. Ohio Dept. of Commerce* (10th Dist. 1981), 2 Ohio App.3d 480,482-83

10. Respondents had ample opportunity to prepare a defense on the Liquidation of Liabilities issues, including hiring experts, and suffered no prejudice from the fact that the Notice of Opportunity for Hearing did not include notice of the disallowance under the Liquidation of Liabilities rule.

11. Whether the costs Respondents reported on the 2003 cost reports are allowable was determined pursuant to Ohio Adm. Code 5101:3-3-01 (eff. 9/30/2001) and the laws, regulations, and rules referred to therein.

12. Reported costs are "allowable" if they are "incurred for certified beds in a facility as determined by [the Department] to be reasonable as set forth in [5101:3-3-01(AA)] ... " Ohio Adm. Code 5101:3-3-01(A) (eff. 9/30/2001).

13. "'Reasonable' means that a cost is an actual cost that is appropriate and helpful to develop and maintain the operation of patient care facilities and activities, including normal standby costs, and that does not exceed what a prudent buyer pays for a given item or services. Ohio Adm. Code 5101 :3-3-01(AA)(eff. 9/30/2001).

14. Pursuant to Ohio Adm. Code 5101:3-3-20(L) (eff. 9/12/2003), Respondents were required to retain current and accurate financial, statistical, and medical records supporting the cost reports or claims for services for six years after all appeal rights relating to the audit reports herein are exhausted. Respondents were also required to make those records available to the Department.

15. A "short-term liability" is a liability due and payable within twelve months. A long-term liability is one due and payable in one year plus one or more days.

16. The Strategic and Providers Choice Annual Services invoices and the Strategic and Providers Choice Enhanced Services invoices were due upon receipt and were therefore short-term liabilities.

17. 42 CFR 213.100 and PRM 2305, which address special treatment of short term liabilities in cost reports when the provider has not expended funds during the current cost reporting period, do not apply in the

prospective payment system used in Medicare.

18. From 1994 through June 30, 2005, Ohio's reimbursement system was based upon reasonable costs and was different than the Medicare prospective payment system.

19. Pursuant to Ohio Admin. Code 5101:3-3-01 (effective 9/30/2001), allowable costs were determined in accordance with a hierarchy of laws and rules as follows: The Ohio Revised Code, then the Ohio Administrative Code, then the Code of Federal Regulations, then the CMS HIM publications or Provider Reimbursement Manual publications and lastly, the general accepted accounting principles (GAAP). Ohio Admin. Code 5101:3-3-01; Ohio Admin. Code 5101:3-3-20.

20. The CFR and PRM are regulations and interpretive guidelines for reportable costs for Medicare cost reports. By including them in the hierarchy of sources to use in determining allowable costs for Medicaid nursing facilities, Ohio adopted these regulations to determine allowable costs for Medicaid cost reports in Ohio. 5101:3-3-01(A) There is nothing in the Revised Code or Ohio Administrative Code that states that certain provisions of the CFR or the PRM are not applicable to reporting costs in a cost report. Moreover, there is nothing in the CFR or the PRM that limits the application of any of the

rules included therein to only Medicare or only Medicaid.

21. Pursuant to 42 C.F.R. 413.100(c)(2)(i)(A), to be reported on the relevant 2003 cost reports at issue in this matter, the Strategic and Providers Choice Annual Services and Enhanced Services invoices had to be liquidated within one year after the end of the relevant cost-reporting periods.

22. In addition to the requirement that a short-term liability be liquidated in a year, the PRM CMS Pub. 15-1 §2305 places an additional requirement, specifically, where liquidation is made by negotiable instrument, "payment must be redeemed through an actual transfer of the provider's assets" within one year after the end of the cost-reporting period.

23. A promissory note is a negotiable instrument.

24. Pursuant to 42 CFR 413.100 and PRM, CMS Pub. 15-1 §2305, the costs for the Strategic and Providers Choice Enhanced Services December 31, 2003, invoices reported on the 2003 cost reports at issue in this matter, are not allowable costs because the first actual transfer of the CHS assets did not occur until 2005, over one year from the end of the cost reporting period.

25. Pursuant to 42 CFR 413.100 and PRM, CMS Pub. 15-1 §2305, the Strategic Annual

Services December 2003 invoice costs reported by Glen Meadows and Wellington Manor are not allowable costs because the invoices were not liquidated within one year after the end of the relevant cost-reporting periods.

26. Pursuant to Ohio Adm. Code 5101:3-3-20(L) (eff. 9/12/2003) and the Provider Reimbursement Manual ("PRM"), CMS Publication 15-1, § 2305 , the Strategic Annual Services January 2004 and February 2004 invoice costs reported by Glen Meadows and Wellington Manor are not allowable costs because the invoices were not liquidated within one year after the end of the relevant cost-reporting periods.

27. Pursuant to 42 CFR 413.100 and PRM, CMS Pub. 15-1 § 2305, the Strategic Annual Services December 2003 invoice costs reported by Terrace View Gardens, Franklin Ridge, Vandalia Park, Glen Meadows, and Wellington Manor are not allowable costs because the invoices were not liquidated within one year after the end of the relevant cost-reporting periods.

28. Pursuant to 42 CFR 413.100 and PRM, CMS Pub. 15-1 § 2305, the Strategic Annual Services November 2003 and December 2003 invoice costs reported by Carington Park are not allowable costs because the invoices were not liquidated within one year after the end of the relevant cost-reporting periods.

29. Pursuant to 42 CFR 413.100 and PRM, CMS Pub. 15-1 § 2305, the Providers Choice Annual Services July 1, 2003, to December 31, 2003, invoice costs reported by East Galbraith Health Care Center are not allowable costs because the invoices were not liquidated within one year after the end of the relevant cost-reporting periods.

30. The adjustments on State's Exhibit 268 are correct.

31. Pursuant to the parties' stipulations, the adjustments on State's Exhibit 267a are correct.

32. PRM 2105.8 specifically prohibits the reimbursement of sporting events.

33. PRM 2105.8 allows reasonable costs "incurred by providers for purposes of employee morale, specifically, for annual employee Christmas or holiday party, an annual employee award ceremony or for sponsorship of employee athletic programs (bowling, softball, basketball teams, etc.)"

34. The 2004 Cincinnati Reds season tickets are a prohibited expense, are not one of, or similar to one of, the listed employee morale examples, and were not conferred during the 2003 cost reporting period. There was no evidence who actually received these tickets. Accordingly, the cost for the 2004 Cincinnati Reds tickets are not allowable costs.

35. Any audit report, report of examination, exit conference report or report of final settlement issued by ODJFS and entered into evidence is to be considered prima facie evidence of what it asserts. Ohio Admin. Code 5101:6-50-09(A)(4).

36. The following patient days/patient liability adjustments are correct:

Facility	**Patient Days/ Patient Liability FY Audit at Issue**	**Adjust-ments to Patient Liability**	**Adjust-ments to No. of Paid Patient Days**
Carington Park	FY 2003	$8,892.76	363.5
Carington Park	FY 2004	$5844.28	167
Carington Park	FY 2005	$2,849.76	337
Carington Park	FY 2006	$10,191.70	374.5
Terrace View Gardens	FY 2003	$6,461.32	296.50
Terrace View Gardens	FY 2004	$910.00	51

Terrace View Gardens	FY 2005	$945.00	19
Terrace View Gardens	FY 2006	-$3,706.00	3.0
Vandalia Park	FY 2003	$8378.65	592.5
Vandalia Park	FY 2004	$0	198
Vandalia Park	FY 2005	$528.42	161.5
Vandalia Park	FY 2006	-$2990.20	441
Franklin Ridge	FY 2003	$1,404.98	175
Franklin Ridge	FY 2004	$2,385.00	93
Franklin Ridge	FY 2005	$1,474.88	61.5
Franklin Ridge	FY 2006	-$1.563.00	7
East Galbraith	FY 2003	$0.00	3
East Galbraith	FY 2004	$405.00	54.5

East Galbraith	FY 2005	$0.00	45
East Galbraith	FY 2006	$2827.64	867
Welling-ton Manor	FY 2005	$0.00	3.5
Wellington Manor	FY 2006	-$18.00	2.5
Glen Meadows	FY 2004	$994.62	11.5
Glen Meadows	FY 2005	$0.00	16
Glen Meadows	FY 2006	-$6,385.00	9

37. Based upon the foregoing findings of fact and conclusions of law, and incorporating the adjustments on State's Exhibits 267a and 268 and on the preceding patient days/patient liability chart, Respondents owe the Department the following amounts for each fiscal year:

Facility	**Audit Issues**	**Amount Owed by CHS**
Carington Park	FY 2003 Patient days/patient liability audit only	$43,509.40

Carington Park	FY 2004 Patient days/ patient liability audit only	$25,067.70
Carington Park	FY 2005 CY 2003 cost report audit and FY 2005 patient days/patient liability audit	$2,586,852.40
Carington Park	FY 2006 CY 2003 cost report audit and FY 2006 patient days/patient liability audit	$2,608,779.73
Terrace View Gardens	FY 2003 Patient days/patient liability audit	$47,821.90
Terrace View Gardens	FY 2004 Patient days/ patient liability audit only	$10,022.77
Terrace View Gardens	FY 2005 CY 2003 cost report audit and FY 2005 patient days/patient liability audit	$564,212.69
Terrace View Gardens	FY 2006 CY 2003 cost report audit and FY 2006 patient days/patient liability audit	$537,237.84

Vandalia Park	FY 2003 Patient days/patient liability audit only	$88,945.40
Vandalia Park	FY 2004 Patient days/ patient liability audit only	$35,340.11
Vandalia Park	FY 2005 CY 2003 cost report audit and FY 2005 patient days/patient liability audit	$270,681.51
Vandalia Park	FY 2006 CY 2003 cost report audit and FY 2006 patient days/patient liability audit	$230,730.54
Franklin Ridge	FY 2003 Patient days/patient liability audit only	$29,858.76
Franklin Ridge	FY 2004 Patient days/ patient liability audit only	$16,407.45
Franklin Ridge	FY 2005 CY 2003 cost report audit and FY 2005 patient days/patient liability audit	$584,324.18

Franklin Ridge	FY 2006 CY 2003 cost report audit and FY 2006 patient days/patient liability audit	$577,418.87
East Galbraith	FY 2003 Patient days/patient liability audit only	$606.54
East Galbraith	FY 2004 Patient days/ patient liability audit only	$30,997.09
East Galbraith	FY 2005 CY 2003 cost report audit and FY 2005 patient days/patient liability audit	$913,384.29
East Galbraith	FY 2006 CY 2003 cost report audit and FY 2006 patient days/patient liability audit	$1,215,526.66
Welling-ton Manor	FY 2005 CY 2003 cost report audit and FY 2005 patient days/patient liability audit	$213,205.07

Wellington Manor	FY 2006 CY 2003 cost report audit and FY 2006 patient days/patient liability audit	$218,261.37
Glen Meadows	FY 2004 Patient days/ patient liability audit only	$1,317.81
Glen Meadows	FY 2005 CY 2003 cost report audit and FT 2005 patient days/patient liability audit	$121,990.35
Glen Meadows	FY 2006 CY 2003 cost report audit and FY 2006 patient days/patient liability audit	$139,057.54

Total: $11,111,557.96

Recommendation

Based upon the foregoing Findings of Fact and Conclusions of Law, it is recommended that ODM adopt the patient days/patient liabilities adjustments as set forth in Attachment D, (attached hereto and incorporated herein), the adjustments in State Exhibit 267a (attached hereto as Attachment A and incorporated herein), and the adjustments in State Exhibit 268 (attached hereto as Attachment B and incorporated herein). It is further recommended that it

be ordered that Respondents owe the Department of Medicaid the amounts set forth in Conclusion of Law No. 37. This recommendation is not a final order, and may be approved, modified or rejected by the Director of the Ohio Department of Medicaid, and shall not become a final order unless and until it is approved by the Director.

10-31-2015
Date

/s/ Mary K. Crawford
Mary K. Crawford
Hearing Examiner
P.O. Box 14366
Columbus, Ohio 43214

CERTIFICATE OF SERVICE

I certify that the original of this document was hand delivered to the Ohio Department of Medicaid, Office of Legal Counsel, 50 W. Town Street, Columbus, Ohio, on November 2, 2015, with instructions that file-stamped copies are to be delivered by Department personnel to the parties and their attorneys of record, if any, in the manner prescribed by law and at the addresses shown in the record of these proceedings.

/s/Mary K. Crawford
Mary K. Crawford

Stipulated Audit Adjustment Amounts for CHS-Lake Erie, Inc. d.b.a. Carington Park, Prov.# 2339268			
COST ACCOUNT NUMBER	**ADJUST-MENT NUMBER**	**ORIGI-NAL ADJUST-MENT INC./ (DEC.)**	**STIPU-LATED ADJUST-MENT AMOUNT**
6001	1	(3,994)	0
6006	1	(1,242)	0
6001	2	(5,642)	(5,642)
6001	3	(45)	(45)
6020	3	(17,641)	0
6001	4	(1,970)	0
6001	5	(1,573)	(1,573)
6006	5	(1,710)	(1,710)
7055	5	54	54
7350	5	3,229	3,229
6001	6	(131)	(131)
6170	8	(25,480)	(25,480)
6530	8	(222,840)	0
7280	9	(129,723)	0

7340	9	(5,545)	0
7340	11	(960)	(960)
8030	11	192	192
E-1	11	960	960
E-1	11	(192)	(192)
8020	12	(1,056)	(1,056)
8030	12	(19,776)	0
8040	12	(65,218)	0
E-1	12	(440,231)	0
E-1	12	177,233	0
E-1	12	(440,231)	0
E-1	12	263,283	0
8020	13	(148)	0
8030	13	(3,205)	0
8065	14	(119,016)	0
8195	15	(1,094,692)	0
8070	16	(11,372)	0
6095	17	(2,904)	0
6230	17	(30,461)	0
7310	17	(653,370)	(4,494)
8090	17	(17,463)	0

Stipulated Audit Adjustment Amounts for CHS-Ohio Valley, Inc. d.b.a Terrace View Gardens, Prov # 2339384			
COST ACCOUNT NUMBER	**ADJUST-MENT NUMBER**	**ORIGI-NAL ADJUST-MENT INC./ (DEC.)**	**STIPU-LATED ADJUST-MENT AMOUNT**
6001	1	(2,666)	(2,625)
6001	2	(1,863)	(1,863)
7025	2	301	301
7120	2	16	16
7350	2	1,546	1,546
6530	3	(128,569)	0
7340	5	(3,431)	0
7340	6	(1,085)	(1,085)
8040	6	164	164
E-1	6	1,085	1,085
E-1	6	(164)	(164)
8020	8	(1,404)	0
8030	8	(1,423)	0
8040	8	(2,617)	0

E-1	8	(52,501)	0
E-1	8	17,052	0
E-1	8	(52,501)	0
E-1	8	22,497	0
8030	9	(167)	0
8040	9	(49)	0
8065	10	(49,682)	0
8195	11	(538,740)	0
A-1	12	4	4
6095	14	(1,175)	0
6230	14	(12,324)	0
7310	14	(141,347)	(1,818)
8090	14	(8,510)	(1,445)
6520	15	(28,002)	0
7065	15	(3,292)	0
7510	15	(4,477)	0

Stipulated Audit Adjustment Amounts for CHS-Miami Valley, Inc. d.b.a Franklin Ridge, Prov # 2339688			
COST ACCOUNT NUMBER	**ADJUST-MENT NUMBER**	**ORIGI-NAL ADJUST-MENT INC./ (DEC.)**	**STIPU-LATED ADJUST-MENT AMOUNT**
6000	1	(2,064)	(2,064)
6001	1	(168)	(168)
6006	1	(1,300)	(1,300)
7025	1	252	252
7055	1	117	117
7220	1	51	51
7320	1	3,112	3,112
6001	2	(1,452)	0
6001	3	(1,559)	(1,559)
6470	4	(1,700)	0
6530	4	(130,622)	0
7280	6	(64,380)	0
7340	6	(4,506)	(399)
7340	7	(1,734)	(1,734)

7340	8	(2,110)	(2,110)
8065	8	2,110	2,110
8030	9	(4,996)	0
8040	9	(6,738)	0
E-1	9	(58,671)	0
E-1	9	27,987	0
E-1	9	(58,671)	0
E-1	9	39,721	0
8040	10	(1,007)	0
E-1	10	(5,035)	0
E-1	10	671	0
E-1	10	(5,035)	0
E-1	10	1,678	0
8030	11	(7,290)	0
8040	11	(18,768)	0
8065	12	(97,186)	0
8195	13	(242,625)	0
8070	14	(11,579)	0
A-1	15	10	10
6095	17	(1,352)	0
6230	17	(14,186)	0

7310	17	(122,743)	(2,093)
8090	17	(8,133)	0
7200	18	(943)	0

Stipulated Audit Adjustment Amounts for CHS-Miami Valley, Inc. d.b.a Vandalia Park, Prov # 2339624			
COST ACCOUNT NUMBER	**ADJUST-MENT NUMBER**	**ORIGI-NAL ADJUST-MENT INC./ (DEC.)**	**STIPU-LATED ADJUST-MENT AMOUNT**
6001	1	(4,959)	(4,959)
6530	1	1,912	1,912
7520	1	420	420
7350	1	2,627	2,627
6001	2	(25,817)	0
6006	2	(1,965)	0
6001	3	(136)	(136)
6001	4	(5,327)	(5,327)
6530	6	(142,376)	(5,225)
7340	7	(8,586)	0
7340	8	(679)	(679)
8020	9	(2,060)	0
8030	9	(13,740)	0
8040	9	(41,734)	0

E-1	9	(287,672)	0
E-1	9	98,759	0
E-1	9	(287,672)	0
E-1	9	142,723	0
8040	10	(8,047)	0
8065	11	(202,325)	0
8195	12	(392,600)	0
8070	13	(15,432)	0
6095	14	(2,277)	0
6230	14	(23,886)	0
7310	14	(242,197)	(3,524)
8090	14	(13,694)	0
7200	15	(757)	0

Stipulated Audit Adjustment Amounts for CHS-Greater Cincinnati, Inc. d.b.a East Galbraith Health Care Center, Prov # 2399033			
COST ACCOUNT NUMBER	**ADJUST-MENT NUMBER**	**ORIGI-NAL ADJUST-MENT INC./ (DEC.)**	**STIPU-LATED ADJUST-MENT AMOUNT**
E-1	1	(159,259)	0
6001	2	(2,875)	(2,875)
6001	3	(3,743)	(3,743)
6006	3	(69)	(69)
7350	3	3,351	3,351
8065	3	461	461
6190	5	(50,705)	0
6530	5	(131,626)	0
7350	6	(3,685)	0
7340	7	(2,537)	(2,537)
8065	8	(43,924)	(6,493)
8195	9	(286,529)	0
6095	11	(792)	0
6230	11	(8,311)	0

7310	11	(83,774)	(1,226)
8090	11	(5,628)	(863)
7200	13	(1,568)	0

Stipulated Audit Adjustment Amounts for CHS-Glenwell, Inc. d.b.a Glen Meadows Prov # 2429330			
COST ACCOUNT NUMBER	**ADJUST-MENT NUMBER**	**ORIGI-NAL ADJUST-MENT INC./ (DEC.)**	**STIPU-LATED ADJUST-MENT AMOUNT**
7070	1	(3,580)	0
7060	1	(220)	0
7220	1	(306)	(306)
7500	1	(1,007)	0
7520	1	(5,990)	0
E-1	1	(172,100)	(172,100)
E-1	1	(517)	(517)
7125	2	(2,414)	(2,414)
6001	3	(7,164)	0
6030	3	(6,029)	0
6001	4	(76)	(76)
6001	5	(270)	(270)
6001	6	(845)	(845)
7025	6	58	58

7120	6	92	92
7220	6	323	323
7350	6	372	372
6530	7	(33,290)	0
6550	7	(5,865)	(4,740)
6530	9	(25,149)	0
6530	10	(30,018)	0
7225	11	(4,652)	0
7265	11	(1,110)	0
7280	11	(19,984)	0
7290	11	(2,099)	0
7340	11	(6,451)	0
7265	12	(2,767)	0
7215	13	(14,071)	0
7340	13	(1,371)	(1,371)
E-1	14	(64,300)	(64,300)
8030	15	(1,607)	0
8040	15	(5,187)	0
8050	15	(1,100)	0
E-1	15	(153,863)	0
E-1	15	95,651	0

8030	16	(654)	0
8040	16	(97)	0
8065	17	(26,081)	0
8195	18	(136,188)	0
A-1	19	8	8
6095	21	(376)	0
6230	21	(3,038)	0
7310	21	(29,064)	(396)
8090	21	(1,529)	0
7200	22	(1,140)	0
E-1	23	(566,294)	(566,294)
E-1	24	(66,274)	(66,274)
6120	25	(1,489)	0
6195	25	(7,176)	0

Stipulated Audit Adjustment Amounts for CHS-Glenwell, Inc. d.b.a Wellington Manor of Butler County. Prov # 2429330			
COST ACCOUNT NUMBER	**ADJUST-MENT NUMBER**	**ORIGI-NAL ADJUST-MENT INC./ (DEC.)**	**STIPU-LATED ADJUST-MENT AMOUNT**
7070	1	(8,048)	0
E-1	1	(274,400)	(274,400)
7125	2	(2,027)	(2,027)
E-1	3	(29,400)	(29,400)
6001	4	(2,152)	0
6006	4	(101)	0
6001	5	(145)	(145)
6006	5	(325)	(325)
7025	5	97	97
7120	5	31	31
7255	5	17	17
7350	5	325	325
6060	6	(1,718)	0
6001	7	(30,000)	(30,000)

6100	9	(2,050)	0
6530	9	(48,681)	0
6530	10	(15,859)	0
7280	11	(18,038)	0
7340	11	(4,854)	0
7520	11	(7,439)	0
7215	12	(10,909)	0
8020	13	(638)	0
8030	13	(1,160)	0
8040	13	(2,194)	0
E-1	13	(90,870)	0
E-1	13	66,268	0
8020	14	(218)	0
8030	14	(668)	0
8040	14	(513)	0
8065	15	(20,103)	0
8195	16	(115,248)	0
6095	18	(281)	0
6230	18	(2,274)	0
7310	18	(21,758)	(296)
8090	18	(1,145)	0

6520	19	(4,648)	0
7065	19	(463)	0
7510	19	(750)	0
E-1	20	(112,536)	(112,536)
E-1	21	(60,470)	(60,470)
6120	22	(2,156)	0

STIPULATED DISPUTED AMOUNT - COST ACCOUNT 6210			
NAME & PROVIDER NO.	ADJUST-MENT NO.	ORIGINAL ADJUST-MENT NO.	STIPU-LATED DISPUTED AMOUNT
CARRING-TON PARK, 2339268	7	(2,395,856)	(2,128,476)
TERRACE VIEW GARDENS, 2339384	4	(727,104)	(610,592)
FRANKLIN RIDGE, 2339688	4 5	(425,00) (153,456)	(284,332) (153,456)
VANDALIA PARK, 2339624	5	(249,552)	(20,796)
EAST GAL-BRAITH HEALTH CARE CENTER, 2399033	4	(555,550)	(430,000)
GLEN MEADOWS, 2429330	8	(39,655)	(39,655)

WELLING-TON MANOR OF BUTLER COUNTY, 2429321	8	(30,741)	(30,741)

After discovering that the Provider No. for Franklin Ridge was incorrect on State Exhibit 268, during the hearing, the parties agreed that the correct number could be inserted in pen on the exhibit. (Tr., Pt. II, pp. 20-21)

STIPULATED DISPUTED AMOUNT - COST ACCOUNT 7215			
NAME & PROVIDER NO.	ADJUST-MENT NO.	ORIGINAL ADJUST-MENT NO.	STIPU-LATED DISPUTED AMOUNT
CARRING-TON PARK, 2339268	9	(625,000)	(520,632)
	10	(44,368)	(44,368)
TERRACE VIEW GARDENS, 2339384	5	(200,000)	(152,251)
	7	(17,749)	(17,749)
FRANKLIN RIDGE, 2339688	6	(200,000)	(200,000)
	7	(54,456)	0
VANDALIA PARK, 2339624	7	(350,000)	(251,379)
	8	(73,621)	(73,621)
EAST GAL-BRAITH HEALTH CARE CENTER, 2399033	6	(350,000)	(350,000)
	7	(15,000)	(15,000)

STIPULATED DISPUTED AMOUNT - REDS TICKETS ISSUE			
NAME & PROVIDER NO.	COST AMOUNT NO.	ADJUST-MENT NO.	STIPU-LATED DISPUTED AMOUNT
TERRACE VIEW GARDENS, 2339384	6530	13	(907)
	7070	13	(113)
	7520	13	(114)
FRANKLIN RIDGE, 2339688	6530	16	(907)
	7070	16	(113)
	7520	16	(114)
EAST GAL-BRAITH, 2399033	7070	10	(113)
	7520	10	(114)
GLEN MEADOW S, 2429330	6530	20	(907)
	7070	20	(113)
	7520	20	(114)

WELLING-TON MANOR 2429324	6530	17	(907)
	7070	17	(113)
	7520	17	(114)

BEFORE THE OHIO DEPARTMENT OF JOB AND FAMILY SERVICES

In the Matters of:

CHS-Glenwell, Inc. 09 LTC 17
CHS-Glenwell, Inc. 09LTC18
CHS-Glenwell, Inc. 09LTC119

CHS-Hamilton County, Inc. 09LTC30
CHS-Hamilton County, Inc. 09LTC31
CHS-Hamilton County, Inc. 09LTC32
CHS-Hamilton County, Inc. 09LTC33

Carington Health Systems 09LTC24
Carington Health Systems 09LTC25

CHS-Miami Valley, Inc. 09LTC13
CHS-Miami Valley, Inc. 09LTC14
CHS-Miami Valley, Inc. 09LTC15
CHS-Miami Valley, Inc. 09LTC16

CHS-Miami Valley, Inc. 09LTC34
CHS-Miami Valley, Inc. 09LTC35
CHS-Miami Valley, Inc. 09LTC36
CHS-Miami Valley, Inc. 09LTC37

CHS-Greater Cincinnati, Inc. 09LTC20
CHS-Greater Cincinnati, Inc. 09LTC21
CHS-Greater Cincinnati, Inc. 09LTC22
CHS-Greater Cincinnati, Inc. 09LTC23

CHS-Lake Erie, Inc. 09LTC26
CHS-Lake Erie, Inc. 09LTC27

CHS-Lake Erie, Inc. 09LTC28
CHS-Lake Erie, Inc. 09LTC29,

Respondents/Providers.

Mary K. Crawford
Hearing Examiner

STIPULATIONS OF THE PARTIES

The Department of Job and Family Services and the Respondents (hereinafter collectively "Carington Health Systems") stipulate and agree that for all purposes in these adjudicatory hearings, and any appeals arising, therefrom that the following stipulations are made, entered into and binding upon the parties as evidenced by the signatures of their counsel, as facts which do not require testimony or other evidence.

It is therefore stipulated by the parties that:

1. Carington Health Systems timely filed a request for adjudicatory hearing in the referenced matters.

2. Carington Health Systems does not, by entering into this stipulation, waive its right to contest on procedural and/or substantive grounds the DJFS's position on and relating to the issue regarding "Liquidation of Liabilities".

3. Carington Health Systems does not waive any objections to the Audit Reports and Reports of Final Settlement previously addressed in this matter by hearing before the Hearing Examiner consisting principally of whether the Department of Job and Family Services ("DJFS") conducted an audit in

compliance with the Ohio Revised Code and Ohio Administrative Codes governing provisions.

4. Notwithstanding the contents of any initial or any amended Audit Report in these proceedings, the parties have agreed to the Proposed Cost Adjustments on State's Exhibits 267.

5. The Proposed Cost Adjustments on State's Exhibit 268 are the sole and only remaining cost report audit adjustment issues (excepting the findings for resident days remain an issue for each of the Carington Health Systems' facilities):

6. With respect to account 6210 on State's Exhibit 268, it is stipulated that:

> **A**. CHS – Lake Erie, Inc. d.b.a. Carington Park, provider number 2339268, entered into an agreement with Strategic Nursing Systems, Inc, at State's Exhibit 57. The costs associated with this consulting agreement were reported in account 6210. Strategic Nursing Systems, Inc. invoiced Carington Park monthly for the consulting fees and Carington Park paid each invoice by check as shown in State's Exhibit 58. The consulting agreement (State's Exhibit 57) contained an Attachment A for Enhanced Services, with an additional consulting fee that was due on December 31, 2003, that was invoiced by Strategic Nursing Services as shown by State's Exhibit 59. Carington Park issued an installment promissory note for the December 31, 2003 for the Enhanced Services invoice, State's Exhibit 60. The payments of the

installment promissory note were per the note's terms and were by checks at State's Exhibit 61.

B. CHS – Hamilton County, Inc. d.b.a. Terrace View Gardens, provider number 2339384, entered into an agreement with Strategic Nursing Systems, Inc. at State's Exhibit 92. The costs associated with this consulting agreement were reported in account 6210. Strategic Nursing Systems, Inc. invoiced Terrace View Gardens monthly for the consulting fees and Tenace View Gardens paid each invoice by check as shown in State's Exhibit 93. The consulting agreement (State's Exhibit 92) contained an Attachment A for Enhanced Services, with an additional consulting fee that was due on December 31, 2003, that was invoiced by Strategic Nursing Services as shown by State's Exhibit 94. Terrace View Gardens issued an installment promissory note for the December 31, 2003 Enhanced Services invoice, State's Exhibit 95. The payments of the installment promissory note were per the note's terms and were by checks at State's Exhibit 96.

C. CHS – Miami Valley, Inc. d.b.a. Franklin Ridge, provider number 2339688, entered into an agreement with Strategic Nursing Systems, Inc. at State's Exhibit 119. The costs associated with this consulting agreement were reported in account 6210. Strategic Nursing Systems, Inc. invoiced Franklin Ridge monthly for the consulting fees and Franklin Ridge paid each invoice by check as shown in State's Exhibit 120.

The consulting agreement (State's Exhibit 119) contained an Attachment A for Enhanced Services, with an additional consulting fee that was due on December 31, 2003, that was invoiced by Strategic Nursing Services as shown by State's Exhibit 121. Franklin Ridge issued an installment promissory note for the December 31, 2003 Enhanced Services invoice, State's Exhibit 122. The payments of the installment promissory note were per the note's terms and were by checks at State's Exhibit 123.

D. CHS – Miami Valley, Inc. d.b.a. Vandalia Park, provider number 2339624, entered into an agreement with Strategic Nursing Systems, Inc. at State's Exhibit 154. The costs associated with this consulting agreement were reported in account 6210. Strategic Nursing Systems, Inc. invoiced Vandalia Park monthly for the consulting fees and Vandalia Park paid each invoice by check as shown in State's Exhibit 155.

E. CHS-Greater Cincinnati, Inc., d.b.a. East Galbraith Health Care Center, provider number 2399033, entered into an agreement with Strategic Nursing Systems, Inc. at State's Exhibit 181. The costs associated with this consulting agreement were reported in account 6210. Strategic Nursing Systems, Inc. invoiced East Galbraith monthly for the consulting fees and East Galbraith paid each invoice by check as shown in State's Exhibit 182. The consulting agreement (State's Exhibit 181) contained an Attachment A for Enhanced Services, with an

additional consulting fee that was due on December 31, 2003, that was invoiced by Strategic Nursing Services as shown by State's Exhibit 183. East Galbraith issued an installment promissory note for the December 31, 2003 Attachment A Enhanced Services invoice, State's Exhibit 184. The payments of the installment promissory note were per the note's terms and were by checks at State's Exhibit 185. The consulting agreement (State's Exhibit 181) also contained an Attachment B for Enhanced Services, with an additional consulting fee that was due on December 31, 2003, that was invoiced by Strategic Nursing Services as shown by State's Exhibit 186. East Galbraith issued an installment promissory note for the December 31, 2003, Attachment B Enhanced Services invoice, State's Exhibit 187. The payments of the installment promissory note were per the note's terms and were by checks at State's Exhibit 188.

7. With respect to account 7215 on State's Exhibit 268, it is stipulated that:

A. CHS – Lake Erie, Inc. d.b.a. Carington Park, provider number 2339268, entered into an agreement with Providers Choice Administrative Services, Inc, at State's Exhibit 63. The costs associated with this consulting agreement were reported in account 7215. Providers Choice Administrative Services, Inc. invoiced Carington Park monthly for the consulting fees and Carington Park paid each invoice by check as shown in State's Exhibit 64.

The consulting agreement (State's Exhibit 63) contained an Attachment A for Enhanced Services, with an additional consulting fee that was due on December 31, 2003. Carington Park issued an installment promissory note for the December 31, 2003 Enhanced Services fee, State's Exhibit 65. The payments of the installment promissory note were per the note's terms and were by checks at State's Exhibit 66.

B. CHS – Hamilton County, Inc. d.b.a. Terrace View Gardens, provider number 2339384, entered into an agreement with Providers Choice Administrative Services, Inc, at State's Exhibit 98. The costs associated with this consulting agreement were reported in account 7215. Providers Choice Administrative Services, Inc. invoiced Terrace View Gardens monthly for the consulting fees and Terrace View Gardens paid each invoice by check as shown in State's Exhibit 99. The consulting agreement (State's Exhibit 98) contained an Attachment A for Enhanced Services, with an additional consulting fee that was due on December 31, 2003. Terrace View Gardens issued an installment promissory note for the December 31, 2003, Enhanced Services fee, at State's Exhibit 100. The payments of the installment promissory note were per the note's terms and were by checks at State's Exhibit 101.

C. CHS – Miami Valley, Inc. d.b.a. Franklin Ridge, provider number 2339688, entered into an agreement with Providers Choice

Administrative Services, Inc., at State's Exhibit 125. The costs associated with this consulting agreement were reported in account 7215. Providers Choice Administrative Services, Inc. invoiced Franklin Ridge monthly for the consulting fees and Franklin Ridge paid each invoice by check as shown in State's Exhibit 126. The consulting agreement (State's Exhibit 125) contained an Attachment A for Enhanced Services, with an additional consulting fee that was due on December 31, 2003. Franklin Ridge issued an installment promissory note for the December 31, 2003, Enhanced Services fee, at State's Exhibit 127. The payments of the installment promissory note were per the note's terms and were by checks at State's Exhibit 128.

D. CHS – Miami Valley, Inc. d.b.a. Vandalia Park, provider number 2339624, entered into an agreement with Providers Choice Administrative Services, Inc., at State's Exhibit 157. The costs associated with this consulting agreement were reported in account 7215. Providers Choice Administrative Services, Inc. invoiced Vandalia Park monthly for the consulting fees and Vandalia Park paid each invoice by check as shown in State's Exhibit 158. The consulting agreement (State's Exhibit 157) contained an Attachment A for Enhanced Services, with an additional consulting fee that was due on December 31, 2003. Vandalia Park issued an installment promissory note for the December 31, 2003, Enhanced Services fee, at State's Exhibit 159. The payments of the

installment promissory note were per the note's tenns and were by checks at State's Exhibit l 60.

E. CHS-Greater Cincinnati, Inc., d.b.a. East Galbraith Health Care Center, provider number 2399033, entered into an agreement with Providers Choice Administrative Services, Inc., at State's Exhibit 190. The costs associated with this consulting agreement were reported in account 7215. Providers Choice Administrative Services, Inc. invoiced East Galbraith monthly for the consulting fees and East Galbraith paid each invoice by check as shown in State's Exhibit 191. The consulting agreement (State's Exhibit 190) contained an Attachment A for Enhanced Services, with an additional consulting fee that was due on December 31, 2003. East Galbraith issued an installment promissory note for the December 31, 2003, Enhanced Services fee, at State's Exhibit 192. The payments of the installment promissory note were per the note's terms and were by checks at State's Exhibit 193.

8. Based upon documents received during the discovery process, DJFS will not proceed on disallowance of costs in accounts 6210 and 7215 on the basis of related party. DJFS will not proceed for disallowance of costs in accounts 6210 and 7215 for inadequate documentation as to Terrace View, Vandalia Park, East Galbraith Health Care Center, Carington Park and Franklin Ridge. As to Wellington Manor and Glen Meadows the record will be held open on the issue of inadequate documentation pending

receipt of cancelled checks and invoices for January and February, 2004, for Account 6210. The DJFS's basis for the proposed disallowance of the costs reported in 6210 and 7215 is that the costs were not timely liquidated as provided by the provisions of 42 CFR §413.100 (Generally described as the "Liquidation of Liabilities Rule") and the provisions of Pub. 15-l §2305(A), §2305.1 and §2305.2.

9. Each party's exhibits are admitted for all relevant purposes.

10. The evidence presented at the Phase I hearing regarding the issue of whether an audit was conducted applies to all seven providers.

IT IS SO AGREED;

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Patient Days and Patient Liability Adjustments

Facility	**Patient Days/ Patient Liability FY Audit at Issue**	**State's Exhibit No.**	**Adjust-ments to Patient Liability**[1]	**Adjust-ments to No. of Paid Patient Days**
Caring-ton Park	FY 2003	242	$8,892.76 p. 19 (column C)	363.5 p. 8 (column E)
Carington Park	FY 2004	243	$5844.28 p. 20 (column C)	167 p. 8 (column E)
Carington Park	FY 2005	244a	$2,849.76 p. 21 (column C)	337 p. 5 (column E)

[1] The patient-liability adjustment amounts in this chart are not the amounts that CHS owes to ODM. The total amounts the CHS facilities owe to ODM are calculated by multiplying the correct number of patient days by the correct rate and subtracting the correct patient liability.

Carington Park	FY 2006	245b	$10,191.70 p. 19 (column C)	374.5 p. 5 (column E)
Terrace View Gardens	FY 2003	246	$6,461.32 p. 15 (column C)	296.50 p. 5 (column E)
Terrace View Gardens	FY 2004	247	$910.00 p. 10 (column C)	51 p. 6 (column E)
Terrace View Gardens	FY 2005	248	$945.00 p. 14 (column C)	19 p. 5 (column E)
Terrace View Gardens	FY 2006	249a	-$3,706. 00 p. 10 (column C)	3.0 p. 5 (column E)
Vandalia Park	FY 2003	250	$8378.65 p. 17 (column C)	592.5 p. 6 (column E)

Vandalia Park	FY 2004	251	$0 p. 17 (column C)	198 p. 6 (column E)
Vandalia Park	FY 2005	252a	$528.42 p. 16 (column C)	161.5 p. 5 (column E)
Vandalia Park	FY 2006	253a	-$2990.20 p. 19 (column C)	441 p. 5 (column E)
Franklin Ridge	FY 2003	254	$1,404.98 p. 17 (column C)	175 p. 6 (column E)
Franklin Ridge	FY 2004	255	$2,385.00 p. 14 (column C)	93 p. 6 (column E)
Franklin Ridge	FY 2005	256a	$1,474.88 p. 15 (column C)	61.5 P. 5 (column E)

Franklin Ridge	FY 2006	257a	-$1.563.00 p. 9 (column C)	7 p. 5 (column E)
East Galbraith	FY 2003	258	$0.00 p. 9 (column C)	3 p. 6 (column E)
East Galbraith	FY 2004	259	$405.00 p. 12 (column C)	54.5 P. 6 (column E)
East Galbraith	FY 2005	260a	$0.00 p. 32 (column C)	45 p. 21 (column E)
East Galbraith	FY 2006	261a	$2827.64 p. 19 (column C)	867 p. 5 (column E)
Welling-ton Manor	FY 2005	262	$0.00 p. 10 (column C)	3.5 p. 5 (column E)

Wellington Manor	FY 2006	263	-$18.00 p. 10 (column C)	2.5 p. 5 (column E)
Glen Meadows	FY 2004	264	$994.62 p. 12 (column C)	11.5 p. 6 (column E)
Glen Meadows	FY 2005	265a	$0.00 p. 12 (column C)	16 p. 6 (column E)
Glen Meadows	FY 2006	266a	-$6,385.00 p. 8 (column C)	9 p. 5 (column E)