STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

SUNRISE COMMUNITY, INC.,	)	
	)	Case Nos. 10-4204
Petitioner,	)	10-4210
	)	10-4211
vs.	)	10-4212
	)	10-4213
AGENCY FOR HEALTH CARE	)	10-4214
ADMINISTRATION,	)	10-4215
	)	10-4216
Respondent.	)	10-4217
________________________________	)	10-4218

RECOMMENDED ORDER

Robert E. Meale, Administrative Law Judge of the Division of Administrative Hearings, conducted the final hearing in Tallahassee, Florida, on January 31 and February 1, 2011.

APPEARANCES

For Petitioner: Steven M. Weinger
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For Respondent: Daniel M. Lake
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STATEMENT OF THE ISSUE

The issue is whether, for the 2001-02 cost-reporting year, Respondent is entitled to recoupment of Medicaid reimbursements that it paid to Petitioner, in connection with its operation of

numerous intermediate care facilities for the developmentally disabled (ICF/DD) and, if so, what is the amount of the overpayments.

PRELIMINARY STATEMENT

By letter dated May 13, 2010, Respondent advised Petitioner that it had completed its audit of Petitioner's cost reports for ten of its ICF/DDs and support facilities for the cost-reporting year ending June 30, 2002. Accompanying the May 13 letter were ten examination reports showing overpayments, by facility, that Respondent was seeking to recoup. Petitioner timely requested a hearing.

The parties settled many of the disputes, leaving the factual issues that have been addressed below. Medicaid reimbursement of ICF/DDs requires the establishment of an historic per diem reimbursement rate for prospective application. However, the disputes in these cases involve only whether specific cost are allowable. The parties have left to Respondent the task of calculating the appropriate per diem rate, taking into account any adjustments contained in the Final Order resulting from this Recommended Order. For the same reason, this Recommended Order does not undertake these per diem calculations either.

At the hearing, Petitioner called three witnesses and offered into evidence Petitioner Exhibits 1, 4, 7, 11-24, 26-36,

and 39. Respondent called one witness and offered into evidence Respondent Exhibits 1-5. All exhibits were admitted except Petitioner Exhibits 11 and 17, which were proffered.

The court reporter filed the transcript on February 17, 2011. The parties filed Proposed Recommended Orders on February 28, 2011.

FINDINGS OF FACT

I. The Audit

1. For over 40 years, Petitioner has operated as a not-for-profit provider of ICF/DD services. These cases involve a compliance audit of ten of Petitioner's 2001-02 cost reports.

2. During 2001-02, Petitioner operated over 300 ICF/DDs--both owned and leased--in eight states and earned an annual revenue of over $90 million. A typical facility is a group home serving 24 developmentally disabled residents, although some of Petitioner's facilities serve much larger numbers of residents.

3. Respondent outsourced the compliance audit of Petitioner's 2001-02 cost reports, as well as a similar audit of Petitioner's 2002-03 cost reports, which are not involved in these cases. Prior to completing the audit, the outside auditor withdrew from the engagement because it had concluded that it would be required to issue a disclaimer of opinion--an auditing nonopinion, as described below.

4. In late 2005, two and one-half years after the outside auditor had commenced its work, Respondent's staff auditors assumed responsibility for the compliance audit. After examining the outside auditor's workpapers, Respondent's staff auditors found it necessary to re-perform at least some of the field work. By letter dated January 3, 2006, Respondent advised Petitioner of this development and, among other things, requested information about 16 identified motor vehicles and

> a statement concerning the 1981 Piper airplane noted in the May 29, 2002 Insurance sub-committee minutes. What was the plane used for and in what cost centers and accounts are the costs recorded? Possible costs would include fuel, insurance, depreciation, maintenance, and any salaries.

5. Petitioner responded by a letter dated March 3, 2006, but this letter is not part of the record. Evidently, not much audit activity took place for the next couple of years. By letter dated January 25, 2008, Respondent advised Petitioner of several potential audit adjustments and noted that Petitioner had not provided the "detail general ledger" and information on aircraft and vehicles that Respondent had sought in its January 3, 2006 letter.

6. In March 2008, Respondent's staff auditor visited Petitioner's main office in Miami and audited Petitioner's records for three days. He confirmed the existence of a 1981 Piper aircraft and a second aircraft, which he was unable to

identify. Respondent's staff auditor determined that he still lacked information necessary to determine if Petitioner's aircraft expenses were reasonable when compared to common-carrier expenses.

7. By letter dated May 12, 2008, Respondent informed Petitioner that, after the March 2008 onsite visit, several issues remained. Among the issues listed were the costs of two private aircraft, for which Respondent requested access to all flight and maintenance logs and detailed documentation of business purpose of trips, identification of aircraft bearing two cited tail numbers, the names of pilots on Petitioner's payroll, and any other cost information justifying the cost of the aircraft compared to common-carrier costs.

8. By letter dated June 13, 2008, Petitioner responded to the May 12, 2008 letter. This letter states that the 1981 Piper was sold at an undisclosed time, and the maintenance logs had been delivered with the plane. The letter supplies registration documentation for the two tail numbers, a personnel file checklist for the pilot, and justification for the cost of operating an aircraft compared to the cost of using common carriers.

9. On December 4, 2008, Respondent's staff auditor conducted an exit conference by telephone with Petitioner's principals and its independent auditor. Respondent's staff

auditor proposed audit adjustments of various cost items that the auditor had guessed involved the aircraft. Petitioner did not agree with these proposed audit adjustments or various others that Respondent's staff auditor proposed.

10. For the next 17 months, neither side contacted the other, until, on May 12, 2010, Respondent issued examination reports for the 2001-02 cost-reporting period. It had taken Respondent over seven years to issue examination reports based on cost reports that Petitioner had filed on February 3, 2003, for a cost-reporting year that had ended almost two years earlier.

II. Cost Items in Dispute

11. On January 28, 2011, Respondent filed a Notice of Filing of a spreadsheet that lists all of the adjustments that have been in dispute. During the hearing, the parties announced the settlement of other cost items. As noted by the Administrative Law Judge, these adjustments are shown on the judge's copy of this filing, which is marked as Administrative Law Judge Exhibit 1 among the original exhibits.

12. Most of the items in dispute are Home Office costs, which are allocated to each of Petitioner's audited facilities. With the reason for disallowance, as indicated in the examination reports, as well as the Schedule of Proposed

Auditing Adjustment (SOPAA) number, the Home Office costs in dispute are:

1. Other consultants. "To disallow out of period costs." $7,000. SOPAA #19.

2. Professional fees--other. "To disallow out of period costs." $1,500. SOPAA #20.

3. Administrative Travel. "To disallow out of period costs." $1,038. SOPAA #21.

4. Transportation--repairs. "To remove airplane costs not documented as being reasonably patient care related." $36,496. SOPAA #22.

5. Transportation--fuel and oil. "To remove airplane costs not documented as being reasonably patient care related." $78,336. SOPAA #22.

6. Insurance. "To remove airplane costs not documented as being reasonably patient care related." $24,000. SOPAA #22.

7. Transportation--Depreciation. "To remove airplane costs not documented as being reasonably patient care related." $106,079. SOPAA #22.

8. Transportation--Interest. "To remove airplane costs not documented as being reasonably patient care related." $57,714. SOPAA #22.

9. Staff Development Supplies. "To remove unreasonable cash awards." SOPAA #26.

13. At the conclusion of the hearing, the Administrative Law Judge encouraged the parties to try to settle as many of the issues as they could and, as to the aircraft issues, consider entering into a post-hearing stipulation due to the lack of

facts in the record concerning this important issue. The parties produced no post-hearing stipulation and have not advised the Administrative Law Judge of any settled issues.

14. The Administrative Law Judge has identified the remaining issues based on the issues addressed in the parties' Proposed Recommended Orders. With two exceptions, the remaining issues are all addressed in each Proposed Recommended Order. One exception is the Country Meadows return-on-equity issue, which neither party addressed. There is a small discrepancy between the amount of this adjustment on Administrative Law Judge Exhibit 1 and elsewhere in the record, so this issue may have been settled. If so, Respondent may ignore the portions of the Recommended Order addressing it. Also, Respondent failed to address the $123,848 in transportation salaries and benefits. Based on the services corresponding to these expenses and the motivation of Respondent's staff auditor in citing these reimbursements as overpayments, as discussed below, the decision of Respondent's counsel not to mention these items is understandable.

15. The remaining issues are thus:

> 10. Burial costs of $4,535 at the Ambrose Center.
>
> 11. Return on equity adjustment of $3,418 at the Country Meadows facility.

12. Legal fees of $4,225 for the Bayshore Cluster as out-of-period costs.

13. Inclusion of state overhead of $9,529 at Mahan Cluster, $9,529 at Dorchester Cluster, and $9,529 at Bayshore Cluster.

14. Transportation Salaries and Benefits of $123,848 at Main Office.

III. Individual Cost Items

A. Burial Costs

16. After the death of an indigent resident at Petitioner's Ambrose Center, the family contacted Petitioner and informed it that they desired a burial, not a cremation, but could not afford to pay for any services.

17. Petitioner's staff contacted several vendors about the cost of a simple burial service and, after negotiating a discount due to the unfortunate circumstances, selected a vendor. The vendor duly performed the burial service, which was attended by survivors of the deceased's group home, and Petitioner paid the vendor $4,535 for the service. For a burial service, the amount paid was reasonable.

18. Petitioner's staff determined that the burial would have therapeutic value to the surviving residents of the deceased's group home. The quality of life of the residents is enhanced to the extent that they identify with each other as family. Petitioner's staff justifiably determined that a burial service would help sustain these familial relationships by

bringing to the survivors a sense of closure, rather than subjecting them to the jarring experience of an unmarked departure of their fellow resident from their lives. However, routine counseling or therapy could have achieved the same results at less cost than a burial service.

B. Out-of-Period Costs

19. The so-called out-of-period costs are $1,038 of rental-car fees, $1,500 of computer consultation fees, $4,225 of legal fees, and $7,000 of "duplicated" insurance broker services. "Out-of-period" means that the expenses were incurred, and should properly be reported, outside of the cost-reporting year ending June 30, 2002.

20. Generally accepted auditing standards (GAAS) and generally accepted accounting principles (GAAP) incorporate the principle of materiality. At least for the purpose of determining the cost-reporting year in which to account for an expense, the materiality threshold for Petitioner is tens of thousands of dollars.

21. The out-of-period issue, which involves the integrity of the cost-reporting year, is different from the other issues, which involve the allowability of specific costs. The cost items under the out-of-period issue are all allowable; the question is in which cost-reporting year they should be included. The test of materiality is thus whether the movement

of these cost items from one cost-reporting year to an adjoining cost-reporting year will distort the results and, thus, Petitioner's Medicaid reimbursements. Given Petitioner's revenues, distortion would clearly not result from the movement of the subject cost items, even if considered cumulatively.

22. In theory, Petitioner could be required to amend the cost report for the year in which any of these expenses were incurred, if they were not incurred in the subject cost-reporting year. Unfortunately, by the time Respondent had generated the SOPAAs, the time for amending the cost reports for the adjoining cost-reporting years had long since passed, so a solution of amending another cost report means the loss of the otherwise-allowable cost. This result has little appeal due to Respondent's role in not performing the audit in a timely, efficient manner, but each out-of-period cost is allowable for different reasons.

23. The car-rental expense arises out of an employee's rental of a car for business purposes in June 2001. The submittal and approval of the travel voucher, which are parts of the internal-control process, did not take place until after June 30, 2001. Although Petitioner's liability to the rental-car company probably attached at the time of the rental, the contingency of reimbursement for an improper rental was not

removed until the internal-control process was completed, so it is likely that this is not an out-of-period expense.

24. The legal expenses included services provided over the three months preceding the start of the subject cost-reporting year. The attorney submitted the invoice to Petitioner's insurer. After determining that Petitioner had not satisfied its applicable deductible, after June 30, 2001, the insurer forwarded the bill to Petitioner for payment. Absent evidence of the retainer agreement, it is not possible to determine if Petitioner were liable to the law firm prior to the insurer's determination that the payment was less than the deductible, so it is unclear whether this is an out-of-period expense.

25. The computer-consulting work occurred about three months before the end of the preceding cost-reporting year, but the vendor did not bill Petitioner until one year later. This is an out-of-period expense.

26. To the extent that these three items may have been out-of-period expenses, it is not reasonable to expect Petitioner to estimate these liabilities and include them in the preceding cost-reporting year. This is partly due to the lack of materiality explained above. For the car-rental and computer expenses, it is also unreasonable to assume that Petitioner's employees responsible for the preparation of the cost reports would have any knowledge of these two liabilities or to require

them to implement procedures to assure timely disclosure of liabilities as modest as these.

27. The last cost item is $7,000 for insurance broker services. This is not an out-of-period expense. In its audit, Respondent determined that this amount represents a sum that was essentially a duplicate payment for services over the same period of time to two different insurance brokers. This is a payment for services over the same period of time to two different insurance brokers for nonduplicated services reasonably required by Petitioner.

28. Given the size and the nature of its operations, Petitioner has relatively large risk exposures that are managed through general liability, automobile liability, director and officer liability, property, and workers' compensation insurance. Paying premiums of $4-5 million annually for these coverages, which exclude health insurance, Petitioner retains insurance brokers to negotiate the best deals in terms of premiums, collateral postings, and other matters.

29. Petitioner experienced considerable difficulty in securing the necessary insurance in mid-2001. At this time, Petitioner was transitioning its insurance broker services from Palmer and Kay to Gallagher Bassett. Difficulties in securing workers' compensation insurance necessitated an extension of the existing policy to July 15, 2001--evidently from its original

termination date of June 30, 2001. Due to these market conditions, Petitioner had to pay broker fees to Palmer and Kay after June 30, 2001, even though, starting July 1, 2001, Petitioner began to pay broker fees to Gallagher Bassett. There was no overlap in insurance coverages, and each broker earned its fee, even for the short period in which both brokers earned fees.

C. Employee Cash Awards

30. Petitioner paid $8,500 in employee cash awards in the 2001-02 cost-reporting year as part of a new policy to provide relatively modest cash awards to employees with relatively long terms of service. For employees with at least 20 years of service, Petitioner paid $100 per year of service. The legitimate business purpose of these longevity awards was to provide an incentive for employees to remain with Petitioner, as longer-tenured employees are valuable employees due to their experience and lack of need for expensive training, among other things.

31. The disallowance arose from the application of a nonrule policy that has developed among Respondent's staff auditors: employee compensation is not an allowable cost unless it is includible in the employee's gross income. The evident purpose of the nonrule policy is to exclude from allowable costs payments to employees who, due to their prominence in the ranks

of the provider, are able to cause the provider to structure the payments so as to avoid their inclusion in the recipient's gross income (and possibly deprive a for-profit provider of an offsetting deduction for the payments).

32. For the 2001-02 cost-reporting year, only three employees qualified for these payments. Two had 30 years of service, so each of them received $3,000, and one had 25 years of service, so he or she received $2,500. The total of the payments at issue is thus $8,500. The record contains ample support for the finding that the addition of $3,000 to the annual compensation paid to any of Petitioner's employees would not result in excessive compensation.

D. Return on Equity

33. During the cost-reporting year, Petitioner maintained $128,000 in a bank account dedicated for the use of the Country Meadows facility. This sum represented about three months' working capital for Country Meadows. At the time, Respondent encouraged providers to maintain cash reserves of at least two months' working capital, so this sum was responsive to Respondent's preferred working capital levels. Consistent with its purpose as working capital, funds in this account were regularly withdrawn as needed to pay for the operation of Country Meadows.

34. The record does not indicate whether the bank paid interest on this account. Also, the concept of return on equity does not apply to a not-for-profit corporation such as Petitioner, which, lacking shareholders, lacks equity on which a return might be calculated or anticipated.

E. <u>State Overhead at Three Clusters</u>

35. This item involves three ICF/DD clusters that, at the time, were owned by, and licensed to, the State of Florida. Petitioner operated the facilities during the cost-reporting year pursuant to a lease and operating agreement.

36. As in prior cost-reporting years, Respondent did not disallow the depreciation included in the subject cost reports for these three clusters. The record does not reveal whether Petitioner or the State of Florida bore the economic loss of these capital assets over time. But the treatment of depreciation costs is not determinative of the treatment of operating or direct care costs.

37. During the subject cost-reporting year, for these three clusters, the State of Florida retained various operational responsibilities, including admissions. However, the costs at issue arise from the expenditures of the State of Florida, not the provider. The costs include the compensation paid to several, state-employed Qualified Mental Retardation Professionals, who performed various operational oversight

duties at the three clusters, and possibly other state employees performing services beneficial to these three clusters. Petitioner never reimbursed the State of Florida for these costs. There is no dispute concerning the reasonableness of the compensation paid these employees by the State of Florida, nor the necessity of these services. The issue here is whether Petitioner is entitled to "reimbursement" for these costs, which amount to $5,139 per cluster, when the costs were incurred by the State of Florida, not Petitioner.

F. Disallowed Transportation Costs and Airplane Costs

38. The $123,848 in disallowed Main Office Transportation salary and benefits represents the salary and benefits of eight Main Office van drivers, who earn about $15,000 per year in pay and benefits. At least 40 residents of the Main Office are not ambulatory, but, like all of the other residents, need to be transported for medical, recreational, and other purposes. There probably remains no dispute concerning these expenses. They are reasonable and necessary.

39. The explanation for why these costs were disallowed starts with the inability of Respondent's staff auditor to find the aircraft expenses in the financial records of Petitioner. It is not possible to determine why the audit failed to identify these expenses prior to the issuance of the examination report. On this record, the only plausible scenario is that Respondent's

outside auditor was off-the-mark on a number of items while conducting the audit, Petitioner's representatives lost patience and became defensive, and, when the outside auditor withdrew from the engagement, Respondent's staff auditors, already fully engaged in other work, may not have had the time to add this substantial responsibility to their workload. It is clear, though, that, after the departure of Respondent's outside auditor, the audit failed due to a combination of the lack of Petitioner's cooperation and Respondent's lack of diligence.

40. Unable to identify the aircraft expenses after years of auditing left Respondent with options. It could have continued the audit process with renewed diligence until it found the aircraft expenses. Or it could have declared as noncompliant the cost report, the underlying financial records, or Petitioner itself. Instead, Respondent converted the examination report from what it is supposed to be--the product of an informed analysis of Petitioner's financial records--to a demand to pay up or identify these expenses and, if related to aircraft, justify them.

41. The problem with Respondent's choice is that, as noted in the Conclusions of Law, an audit requires Respondent to proceed, on an informed basis, to identify the expenses, analyze them, and, if appropriate, determine that they are not allowable--before including them as overpayments in an

examination report. Proceeding instead to cite overpayments on the basis of educated guesses, Respondent entirely mischaracterized the $123,848 in transportation salaries and benefits, which did not involve any aircraft expenses.

42. Respondent's educated guesses were much better as to the remaining items, which are $36,496 in transportation repairs, $78,336 in transportation fuel and oil, $24,000 in insurance, $106,079 in transportation depreciation, and $57,714 in transportation interest. But the process still seems hit-or-miss. Thinking that he had found the pilot's salary in the item for the van drivers' salaries, Respondent's staff auditor missed the pilot's salary, which was $30,000 to $40,000, as it was contained in an account containing $1.3 million of administrative salaries. Respondent's staff auditor also missed the hanger expense, which Petitioner's independent auditor could not find either.

43. On the other hand, Respondent's staff auditor hit the mark with the $78,336 of fuel and oil, $106,079 of depreciation, and $36,496 in repairs--all of which were exclusively for Petitioner's aircraft. Respondent's staff auditor was pretty close with the transportation interest, which was actually $60,168. It is difficult to assess the effort of Respondent's staff auditor on insurance; he picked a rounded number from a

larger liability insurance account, which includes aircraft insurance, but other types of insurance, as well.

44. Respondent correctly notes in its Proposed Recommended Order that the auditing of aircraft expenses requires, in order, their identification, analysis, and characterization as allowable or nonallowable. As Respondent argues, the analysis must compare the aircraft expenses to other means of transportation or communication to determine the reasonableness of the aircraft expenses. As Respondent notes elsewhere in its Proposed Recommended Order, the analysis also must ensure that a multijurisdictional provider, such as Petitioner, has fairly allocated its allowable costs among the jurisdictions in which it operates.

45. Although Respondent's staff auditor found a number of aircraft expenses, he did not try to compare these expenses with other means of travel or communication, so as to determine the reasonableness of these aircraft expenses, or determine if Petitioner had allocated these costs, as between Florida and other jurisdictions, in an appropriate manner. The failure of the examination report, in its treatment of the expenses covered in this section, starts with the failure to secure the necessary information to identify the expenses themselves, but continues through the absence of any informed analysis of these expenses.

46. Respondent's staff auditor used the examination report's treatment of the items covered in this section as a means to force Petitioner both to identify and explain these costs. The fact that Respondent's staff auditor guessed right on many of the aircraft expenses does not mean that he had an informed basis for these guesses. At one point during his testimony, Respondent's staff auditor seemed pleasantly surprised that he had been as accurate as he was in finding these expenses. But, regardless of the basis that he had for the identification of these expenses, Respondent's staff auditor never made any effort to analyze the expenses that he had chosen to include in the examination report as aircraft expenses.

47. Nor is the record insufficient to permit such analysis now. Among the missing data is the number of planes that Petitioner owned at one time during the subject cost-reporting year. It is now clear that, for awhile, the number was two, probably at the end of the cost-reporting year, but this was unknown at the time of the issuance of the examination report. It is unclear, even now, for how long Petitioner owned two planes, or whether it operated both planes during the same timeframe. Cost comparisons are impossible without the knowledge that the cost-comparison exercise is for one or two private aircraft.

48. Likewise, Respondent lacked basic information about the aircraft, such as the planes' capacities and costs of operation, per hour or per passenger mile. Again, this information remains unknown, so it is still impossible to establish a framework for comparison to the costs of common carriers.

49. The record includes a three-page log provided during the audit process by Petitioner to Respondent, which appears never to have analyzed it, probably due to its determination that it had not identified the aircraft expenses adequately. The log shows 118 trips for purposes other than maintenance or engineering during the subject cost-reporting year. The log shows the cities visited and a very brief description of the purpose of the trip. Not the detailed description requested by Respondent, the proffered description is often not more than the mention of a facility or meeting. The log does not show the duration of the trip, but often notes the number of persons on the plane.

50. If the aircraft costs identified above, including the unassessed pilot salary, are divided by the number of trips, the per trip cost is about $2,600. Some trips list several persons, as many as seven. Some trips list only one or two persons. Some trips list "staff," so it is impossible to tell how many persons traveled. And some trips provide no information about

the number of travelers. It is a close question, but these findings alone do not establish that the use of the aircraft was unreasonable when compared to common carriers.

51. Also, Respondent lacked any information about the purpose of the trips, so as to be able to determine if they were necessary or whether they could have been accomplished by videoconference or telephone. And the hearing did not provide this information.

52. Respondent's staff auditor also never considered allocation methods, which is understandable because this analysis would necessarily have followed the identification process, in which he justifiably lacked confidence, and the cost-comparison analysis, which he had never undertaken. At the hearing, Respondent's staff auditor briefly mentioned other allocation methods, but never criticized the approved allocation method used by Petitioner. Although an approved allocation method might not offset disproportionate travel expenses to West Virginia and Connecticut, the record is insufficient to determine that the chosen allocation method was inappropriate or transferred excessive expenses to Florida for Medicaid reimbursement.

CONCLUSIONS OF LAW

I. General

53. The Division of Administrative Hearings has jurisdiction over the subject matter. §§ 120.569 and 120.57(1), Fla. Stat.

54. Congress provides a grant to each state that adopts a plan meeting various requirements under federal law for medical assistance programs (Medicaid). 42 U.S.C. § 1396 (2002). (Except as otherwise indicated, all authority is that which was in effect in 2002.) The federal Medicaid requirements are in Title XIX, Social Security Act, 42 U.S.C. §§1396 et seq. Pursuant to 42 U.S.C. § 1396a(a)(30)(A), each state medical assistance plan must:

> . . . assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area[.]

55. As part of the Florida Medicaid program, the Florida legislature has designated Respondent as the state agency to make payments to qualified providers for medical assistance and related services under Title XIX, Social Security Act, subject to applicable federal and state law. § 409.902, Fla. Stat. Providers of covered services to eligible persons residing in

licensed ICF/DDs may receive Medicaid reimbursements, subject to the availability of funds. § 409.904(3), Fla. Stat.

56. Subject to specific authorizations, Respondent is required to reimburse Medicaid providers, in accordance with federal and state law, "according to the methodologies set forth in the rules of the agency and in policy manuals and handbooks incorporated by reference therein." § 409.908, Fla. Stat. Medicaid "is the payor of last resort for medically necessary goods and services furnished to Medicaid recipients." § 409.910(1), Fla. Stat.

57. The details of Florida's Medicaid program are found in Respondent's rules--specifically, Florida Administrative Code Chapter 59-G--and the materials incorporated by reference by the rules. (All references to rules of the Florida Administrative Code are to the 2010 rules. Neither party provided the 2002 rules to the Administrative Law Judge, who was unable otherwise to obtain the rules in effect in 2002.) Florida Administrative Code Rule 59G-1.001 states these rules "must be read in conjunction with the statutes, federal regulations, and all other rules and regulations pertaining to the Medicaid program."

58. Florida Administrative Code Rule 59G-6.045 provides that reimbursement to privately owned Intermediate Care Facilities for the Mentally Retarded and Developmentally

Disabled (ICF--MR/DD) shall be in accord with the Florida Title XIX ICF/MR-DD Reimbursement Plan (Plan).

59. The Plan is divided into several sections. The first section describes "Cost Finding and Cost Reporting" and describes how a provider is to account for and report its costs. The Plan requires that each provider submit a cost report within three months after the close of the cost-reporting year. Plan § I.A. Providers must detail all of their costs for the entire reporting period, making appropriate adjustments, as required by the Plan, for the determination of "allowable costs." Plan § I.C. Continuing to address methodology, Plan § I.C. requires providers to use the accrual method of accounting, in accordance with GAAP; the Medicare (Title XVIII) Principles of Reimbursement; the Provider Reimbursement Manual HCFA Pub. 15-1 (1993) (now known as CMS Pub. 15-1), which is incorporated by reference by Florida Administrative Code Rule 59G-6.010; and applicable rules in the Florida Administrative Code.

60. Other provisions of section I of the Plan address the cost-reporting process. Providers' cost reports must be "current, accurate, and in sufficient detail to support costs set forth in the report." Plan § I.F. This requirement extends to all ledgers, books, records, original evidence of cost, and other records in accordance with CMS Pub. 15-1, "which pertain

to the determination of allowable costs, and must be capable of being audited . . .." Plan § I.F.

61. Section II of the Plan covers audits. All audits must be based on "generally accepted auditing standards of the [American Institute of Certified Public Accountants], as incorporated by reference by Rule 61H1-20.008, F.A.C. (10-19-94)." Plan § II.A.2. The cited rule provides:

> auditing standards generally accepted in the United States of America in effect as of June 30, 2002, including, but not limited to, general, field work and reporting standards approved and adopted by the membership of the American Institute of Certified Public Accountants (AICPA), as amended by the AICPA Auditing Standard Board (ASB) and standards promulgated by the ASB in the form of Statements on Auditing Standards (entitled Codification of Statements on Auditing Standards, (including Statements on Standards for Attestation Engagements) Numbers 1 to 93, dated 2001, available from the AICPA's Resource Online at www.cpa2biz.com or call 1(888)777-7077).

62. Inconveniently, the website provides only an opportunity to purchase the GAAS. However, GAAS is detailed in Newby v. Enron Corp. (In re Enron Corp. Secs., Derivative & ERISA Litig.), 2010 U.S. Dist. LEXIS 130386, 165-170 (S.D. Tex. Dec. 8, 2010):

> GAAS . . . refers to ten quite specific standards: three General Standards, three Standards of Field Work, and four Standards of Reporting. These standards have remained virtually untouched since their adoption by

the AICPA in 1947. . . . GAAS is composed of[:]

General Standards

1. The auditor must have adequate technical training and proficiency to perform the audit.
2. The auditor must maintain independence in mental attitude in all matters relating to the audit.
3. The auditor must exercise due professional care in the performance of the audit and the preparation of the report.

Standards of Field Work

1. The auditor must adequately plan the work and must properly supervise any assistants.
2. The auditor must obtain a sufficient understanding of the entity and its environment, including its internal control, to assess the risk of material misstatement of the financial statements whether due to error or fraud, and to design the nature, timing, and extent of further audit procedures.
3. The auditor must obtain sufficient appropriate audit evidence by performing audit procedures to afford a reasonable basis for an opinion regarding the financial statements under audit.

Standards of Reporting

1. The auditor must state in the auditor's report whether the financial statements are presented in accordance with generally accepted accounting principles (GAAP).
2. The auditor must identify in the auditor's report those circumstances in which such principles have not been consistently observed in the current period in relation to the preceding period.
3. When the auditor determines that informative disclosures are not reasonably

> adequate, the auditor must so state in the auditor's report.
> 4. The auditor must either express an opinion regarding the financial statements, taken as a whole, or state that an opinion cannot be expressed, in the auditor's report. When the auditor cannot express an overall opinion, the auditor should state the reasons therefor in the auditor's report. In all cases where an auditor's name is associated with financial statements, the auditor should clearly indicate the character of the auditor's work, if any, and the degree of responsibility the auditor is taking, in the auditor's report. Id. at n. 43.

63. Enlarging on the auditor's responsibilities, the Enron court cites Jay M. Feinman, "Liability of Accountants for Negligent Auditing: Doctrine, Policy, and Ideology," 31 Fla. St. U. L. Rev. 17, 21-22 (Fall 2003):

> An audit is a systematic, objective examination of a company's financial statements. As accountants frequently point out in debates about liability, the company, not the accountant, prepares the financial statements. The purpose of an audit is to determine if the statements fairly present the financial condition of the company by determining that they have been prepared in accordance with Generally Accepted Accounting Principles (GAAP), applied on a consistent basis. . . . GAAS and the interpretive Statements on Auditing Standards (SAS) . . . govern the conduct of audits.
>
> After concluding the audit, the auditor issues its report. The report expresses the auditor's independent, professional opinion about the fairness of the financial statements and, depending on the result of the audit, may be one of several kinds:

> An unqualified opinion states that the accountant followed GAAS and that the financial statements fairly present the financial condition of the company in accordance with GAAP. An unqualified opinion may sometimes contain explanatory language, as when the company has changed its accounting practice or when there is an unresolved uncertainty, such as significant pending litigation. As a practical matter, an unqualified opinion is almost a necessary result of an audit of large, publicly held companies, and of smaller companies when an audit is needed to satisfy lenders or investors. If the auditor discovers discrepancies that may require a qualified report, the auditor often will discuss, negotiate, and attempt to remedy the difficulties.
>
> A qualified opinion states exceptions to the observance of GAAS, where the scope of the audit is limited or the auditor is unable to obtain necessary information, or to the fairness of the statements in accordance with GAAP, when the principles have not been observed or when not all necessary disclosures have been made.
>
> An adverse opinion states that the financial statements are not fairly stated in conformity with GAAP.
>
> A disclaimer of opinion is not an opinion at all; rather the accountant states that the scope of the audit was not sufficient to enable it to render an opinion.

Enron Corp., 2010 U.S. Dist. LEXIS 130386 at 168-70.

64. The Plan requires the auditor to issue a report that meets GAAS. Plan § II.A.3. Specifically, the auditor "must express an opinion as to whether, in all material respects, the

financial and statistical report complies with all federal and state regulations pertaining to the reimbursement program for long-term care facilities." Id. Providers may request an administrative hearing, pursuant to chapter 120, Florida Statutes. Plan § II.A.4.

65. Section III of the Plan defines "allowable costs." This section is divided generally into six parts:

> 1. All expense items that a provider must "incur" to meet the definition of ICF contained in 42 CFR § 440.150 (1997); the standards prescribed for ICFs in 42 CFR Part 442, Subpart C (1997); the requirements established by the state agency responsible for establishing and maintaining health standards; and any other requirements for licensing under Florida law applicable to long-term care facility services.
>
> 2. All therapy required by Medicare or Medicaid certification standards and prescribed by the physician of record "shall be considered as covered services and all costs, direct or indirect, shall be included in the cost report."
>
> 3. Allowable costs may not exceed what a "prudent and cost-conscious buyer pays for a given service or item."
>
> 4. "All items of expense which providers incur in the provision of routine services, such as the regular room, dietary and nursing services, medical supplies, and the use of equipment and facilities, are allowable[,] although services covered by other Florida Medicaid programs are not allowable under the Plan. Relevant limitations are in the Florida Medicaid ICF/MR-DD Services Coverage and Limitations Handbook and rule 59G-4.170.

> 5. Bad debts are not included in allowable costs, subject to several exceptions.
>
> 6. Miscellaneous provisions address the compensation of key employees, the limitations on rent, methods of calculating depreciation on capital assets, limitations on interest, limitations on return on equity, and limitations on property-related costs allowed for reimbursement.

Plan § III.A.-G.

66. Concerning the first of these six parts, an ICF/DD operator must "provide or arrange for active treatment services by an interdisciplinary team to maximize individual independence or prevent regression or loss of functional status." § 400.962(4), Fla. Stat.

67. Florida Administrative Code Rule 59G-4.170(7) provides for reimbursements as follows:

> (a) The Medicaid payment is an all inclusive payment designed to reimburse a facility for expenses incurred in providing daily care to Medicaid recipients.
> (b) Items of necessary expense incurred by the ICF/MR provider in providing resident care shall be included as allowable costs in the ICF/MR's cost report and shall not be charged to the recipient. These allowable costs are defined as items of expense that the provider is required to incur in furnishing intermediate care services or any expenses incurred in complying with state licensure or federal certification requirements.
> (c) The Medicaid payment includes, but is not limited to, reimbursement for the following services:

1. Room and board including all of the items necessary to furnish the individual's room;

2. Direct care and nursing services as required for each resident at his particular level of care;

* * *

4. Training and assistance as required for the activities of daily living, including, but not limited to, toileting, bathing, personal hygiene, eating and ambulation as appropriate;

5. Walkers, wheelchairs, dental services, eyeglasses, hearing aids and other prosthetic or adaptive equipment as needed. The amount allowed in the Medicaid cost report is limited to the AHCA fee schedule as applicable. If any of these services are reimbursable under a separate Medicaid program, the cost will be disallowed in the cost report;

6. Therapies, including speech, recreational, physical, and occupational, as prescribed by the resident's individual habilitation plan;

7. Transportation services, including vehicles with lifts or adaptive equipment, as needed.

(d) The Medicaid payment does not provide reimbursement for the following:

1. Legend drugs provided to the recipient through the prescribed drug program. The facility handles prescribed drugs for the resident by supplying the Medicaid identification card to the pharmacy.

2. Personal laundry services, unless part of a training program, may be charged to the resident by the facility.

* * *

(f) All ICF/MR providers enrolled in the Medicaid program must be in compliance with the provisions of the Medicaid Provider Handbook for Intermediate Care Facility for the Mentally Retarded Services, as updated December 1, 1992, which is incorporated by

reference into this rule and available from
the fiscal agent contractor.

68. These allowable costs are largely reiterated in the ICF/DD Coverage and Limitations Handbook, Chapter 2. The Coverage and Limitations Handbook adds detail to these costs and identifies other specific costs that are allowable. Allowable costs are for recreational and leisure services that modify, ameliorate or reinforce specific physical or social behaviors, transportation suited to the needs of the residents, and certain other medical services. Id. The intent is for the per diem rate to include "all services and items necessary to ensure appropriate care." Coverage and Limitations Handbook, p. 3-2.

69. Other provisions of authoritative materials addressing allowable costs pertain to specific cost items, so they will be addressed in the sections below covering the cost items to which they pertain.

70. The burden of proof is on Respondent to show an overpayment of Medicaid reimbursements. Southpointe Pharmacy v. Dep't of Health & Rehab. Services, 596 So. 2d 106, 109 (Fla. 1st DCA 1992); S. Medical Services v. Agency for Health Care Admin., 653 So. 2d 440, 441 (Fla. 3d DCA 1995) (per curiam). See also § 409.913(20), Fla. Stat. ("In meeting its burden of proof in any administrative or court proceeding, the agency may introduce

the results of such statistical methods as evidence of overpayment.") (Emphasis supplied.)

71. In Golfcrest Nursing Home v. Agency for Health Care Admin., 662 So. 2d 1330, 1334 (Fla. 1st DCA 1995), court imposed the burden of proof on the Medicaid provider that was seeking an interim rate increase. The court explained that the provider was asserting the affirmative of the issue. This case is distinguishable because the affirmative of the issue here is Respondent's entitlement to recovery of overpayments.

72. The standard of proof is a preponderance of the evidence. § 120.57(1)(j), Fla. Stat.; Southpointe Pharmacy, 596 So. 2d at 109.

73. The hearing is de novo. § 120.57(1)(k), Fla. Stat. In the context of the present case, a de novo hearing means that the provider may introduce evidence that it did not present during the audit. Wistedt v. Dep't of Health & Rehab. Services, 551 So. 2d 1236 (Fla. 1st DCA 1989); HBA Corp. v. Dep't of Health & Rehab. Services, 482 So. 2d 461, 468 (Fla. 1st DCA 1986) (dictum).

74. In an overpayment case, Respondent satisfies its burden of proof by making a prima facie case. Section 409.913(22) provides: "The audit report, supported by agency work papers, showing an overpayment to a provider constitutes evidence of the overpayment."

75. However, the audit report--or, as it is sometimes called, the examination report--establishes a prima facie case only if Respondent satisfies all applicable requirements concerning the audit. Most importantly, section 409.913(20) requires: "In making a determination of overpayment to a provider, the agency must use accepted and valid auditing, accounting, analytical, statistical, or peer-review methods, or combinations thereof." On its face, this statute requires Respondent to identify and analyze the cost reports before issuing an examination report.

76. Making a prima facie case requires a showing of compliance with all applicable conditions precedent. See, e.g., Berg v. Bridle Path Homeowners' Ass'n, 809 So. 2d 32, 34 (Fla. 4th DCA 2002) (homeowners' association must prove compliance with all applicable provisions of covenants).

II. Burial Costs

77. The cost of the burial service is reasonable, but the question remains whether it is allowable. The cost must be examined from two perspectives: the perspective of the deceased and the perspective of the surviving residents who shared the group home with the deceased at the time of his or her death.

78. From the perspective of the deceased and the need for final disposition of the remains, the payor of last resort for burial expenses is not Medicaid. Florida has a fairly elaborate

statutory framework for allocating the costs of the disposition of the bodies of persons whose estates are insufficient to pay final expenses. Unless a surviving family member objects, any person coming into a possession of an unclaimed dead body, unless it has been crushed, severely decomposed, autopsied, or ravaged by contagious disease, must contact the state Anatomical Board at the University of Florida Health Center and, if requested, deliver the body to the state Anatomical Board for medical education and research. § 406.50, Fla. Stat. The state Anatomical Board assumes the financial responsibility for the disposition of the remains, once it is through with them. § 470.002(11), Fla. Stat. If the state Anatomical Board determines that it has too many bodies or a particular body is unfit for anatomical purposes, it may contact the county commissioners of the county in which the person died and require them to dispose of the body at their expense. § 406.52, Fla. Stat. Thus, from the perspective of the deceased, the burial costs are not allowable because other entities are available to pay this expense.

79. Petitioner claims that the burial services had a therapeutic effect on the other residents of the group home. The record is not particularly well-developed on this point, but the idea of guided closure for residents who may have a very imperfect understanding of death is not difficult to accept.

80. In its Proposed Recommended Order, Petitioner contends that the applicable rate plan was prepared so that the costs of the provider would be allowed up to the maximum limits of the rate plan, absent a specific exclusion covering the cost item in question. Thus, Petitioner argues, a funeral expense is allowable because it is not specifically excluded. Petitioner's Proposed Recommended Order, para. 10. Respondent contends in its Proposed Recommended Order that an authoritative source must specifically cover a cost item for it to be allowable. Respondent's Proposed Recommended Order, para. 23.

81. As rules of interpretation, these two approaches should assist, rather than displace, the basic exercise of determining whether the burial expense is an allowable cost. This exercise starts with the acknowledgement that the coverage provisions of the Plan are very broad. Plan, III.A; § 400.962(4), Fla. Stat.: an ICF/DD operator must "provide or arrange for active treatment services by an interdisciplinary team to maximize individual independence or prevent regression or loss of functional status." Section III.C of the Plan limits allowable costs to reasonable costs in terms of a prudent buyer. Here, the death of a resident may necessitate counseling and therapy for the survivors, but anything more violates the reasonableness standard.

82. Thus, the reimbursement of $4,535 for burial costs is an overpayment subject to recoupment by Respondent.

III. Out-of-Period Costs

83. Although there may be some question as to the status of the other costs in this section, the $7,000 of duplicated insurance broker services is clearly not an out-of-period cost. In a difficult insurance market, Petitioner had to expend funds for two insurance brokers. These costs were reasonable and incurred for services performed during the subject cost-reporting year.

84. The Plan, CMS Pub. 15-1, and GAAP require Petitioner to use the accrual method of accounting. The Department of the Treasury offers a brief explanation of this method of accounting for income and expense items:

> (ii) Accrual method. (A) Generally, under an accrual method, income is to be included for the taxable year when all the events have occurred that fix the right to receive the income and the amount of the income can be determined with reasonable accuracy. Under such a method, a liability is incurred, and generally is taken into account for Federal income tax purposes, in the taxable year in which all the events have occurred that establish the fact of the liability, the amount of the liability can be determined with reasonable accuracy, and economic performance has occurred with respect to the liability.

26 C.F.R. § 1.446-1(c)(1)(ii).

85. All but one of the cost items at issue here raise the question of the integrity of the cost-reporting year for an accrual-basis provider. For the reasons noted in the Findings of Fact, none of these cost items is not large enough to affect in any meaningful way the determination of Petitioner's per diem rate for the subject cost-reporting year or an adjoining cost-reporting year.

86. Another issue is fairness or estoppel. Timely compliance auditing might have allowed Petitioner to restate these items in the cost-reporting year in which they accrued, if different from the subject cost-reporting year.

87. Even if materiality and fairness did not preclude a finding of overpayment of these costs, accounting and auditing principles permit their allowance in the subject cost-reporting year. A rule of reason applies to GAAP and tax accounting. CMS Pub. 15-1 alludes to this rule of reason in its treatment of discounts, allowances, refunds, and rebates that are provided after the cost-reporting year of the transaction to which the adjustment pertains. CMS Pub. 15-1, § 804 provides in part:

> Discounts, allowances, refunds, and rebates are not to be considered a form of income. Rather, they should be used to reduce the specific costs to which they apply in the accounting period in which the purchase occurs.
>
> Where the purchase occurs in one accounting period and the related allowance or refund

> is not received until the subsequent period, where possible, an accrual in the initial period should be made of the amount if it is significant, and cost correspondingly reduced. However, if this cannot be readily accomplished, such amounts may be used to reduce comparable expenses in the period in which they are received.
>
> Rebates in the form of cash payments on the total value of purchases in one accounting period are not generally received until the subsequent accounting period. Where the amount of the rebate can be determined, it should be accrued in the initial period and costs for that period correspondingly reduced. A reasonable effort should be made to accrue accurate amounts for allowances and rebates which will be received after the books have been closed. The difference between the accrual and the actual amount received may then be entered in the period in which it is actually received. Where a number of cost centers have received numerous charges from purchases, a rebate in recognition of the total of such purchases should be credited to these cost centers based on an equitable method of allocation.

88. The message here is that, when dealing with a material item, an accrual-basis provider must make a reasonable effort to accrue accurate estimates of costs in the cost-reporting year in which they were incurred, even if these costs cannot be identified with precision.

89. The $1,038 of rental-car fees is probably not out-of-period. Under the "all-events test" described in the Treasury regulation quoted above, liability for this June 2001 expenditure likely did not attach until internal controls

demonstrated that this was a legitimate business expense, not a rogue employee on a lark. Even if out-of-period, though, this expense is clearly not material, and it is unreasonable to require Petitioner to estimate this expense in time to include it in the 2001-02 cost-reporting year.

90. The $1,500 of computer consulting fees is out of period, but clearly not material. Invoiced a year after the performance of the service, it appears that the vendor forgot about the service, so it is unreasonable to expect Petitioner to have knowledge of the claim and take the time to estimate this minor expense for the 2001-02 cost-reporting year.

91. The $4,225 of legal fees is possibly not out of period, depending on the reasonableness of Petitioner's expectation that its insurance deductible may not apply, so as to spare it the expense. Compared to the car-rental and computer expense, more may be reasonably expected of Petitioner's contemporaneous knowledge of this item, not due to the size of the legal bill, but due to the exposure involved in what appeared to be a defense of a tort claim. Under any set of circumstances, the expense itself fails the materiality test. Whether included in one cost-reporting year or the next simply does not matter.

92. Thus, the reimbursements of these so-called out-of-period costs are not overpayments.

IV. Employee Cash Awards

93. It is difficult to understand the problem that Respondent has with this item. Even with these longevity bonuses, nothing in the record suggests excessive compensation for these three employees. If Petitioner had paid a bonus to the three employees involved in this issue, and the bonus had been included in their gross income for federal income tax purposes, Respondent would not have disputed this compensation as an allowable cost. The issue arises here due to Respondent's application of its nonrule policy that compensation is an allowable cost only to the extent that it is included in the gross income of the recipient.

94. This policy needs some work. The longevity payments may have been designed in response to sections 74(c)(1) and 274(j), Internal Revenue Code, as amended. If so, the longevity-award program is not permitted to discriminate in favor of highly compensated employees, and all sums in excess of $1,600 per year will be included in the recipient's gross income. So, even if Respondent's nonrule policy applied here, it would not disallow all of the payments.

95. In fact, though, no ground exists to disallow any part of these payments because they are part of the fair compensation paid to Petitioner's employees for covered services. Thus, the

reimbursements of these payments to employees are not overpayments.

V. Return on Equity

96. The money in the bank account for Country Meadows is working capital. It is not disallowable as some sort of invested fund.

97. CMS Pub. 15-1, § 1218.2 provides:

> Invested Funds.--Invested funds are funds diverted to income producing activities which are not related to patient care. Any portion of the provider's general funds or operating funds invested in such activities for more than 6 consecutive months is not includable in the provider's equity capital. For example, funds deposited in a savings account or invested in securities or loans are considered "invested funds". Further, if the time period covered by such fund investment is interrupted by a number of withdrawals and redeposits so that the effect of such transactions is that funds are invested for more than 6 consecutive months, these invested funds are not included in equity capital.

98. Under this definition, the money earmarked for Country Meadows is not an invested fund because it did not remain, undisturbed, for more than six months.

99. However, any reimbursement to Petitioner for return on equity raises another problem. Return on equity is "limited to those providers who are organized and operated with the expectation of earning a profit for the owners, as distinguished from providers organized and operated on a non-profit basis."

Plan, § III.H. Petitioner is a not-for-profit, so it has no owners or, thus, equity.

100. Thus, the reimbursement of $3,418 for return on equity is an overpayment subject to recoupment by Respondent.

VI. State Overhead at Three Clusters

101. This is an expense involving therapy that, if incurred by Petitioner, is clearly an allowable cost. The problem here is that the expense was incurred by the State of Florida, not Petitioner. State-employed therapists providing medically necessary therapy to some of Petitioner's residents did so at no charge, direct or indirect, to Petitioner.

102. Petitioner argues that its per diem rate should include this imputed cost. Imputed costs may be allowable, even when they bear no resemblance to economic reality. For instance, during inflationary periods in real property, depreciation or amortization of a building may generate an allowable cost that has no correspondence to the market value of the capital item, although recapture will--in a later, perhaps much later, cost-reporting year--somewhat offset this economic anomaly. In this vein, Respondent allowed Petitioner a depreciation cost for these three clusters, even though Petitioner bore little, if any, of the economic loss over time of these capital assets.

103. But allowing an imputed cost of therapy is another matter. Nothing in the Plan authorizes imputing therapy costs, except in one case, involving employees who are unpaid by the charitable organization that employs them. CMS Pub. 15-1, §§ 700, et seq. These detailed provisions allow a provider to report the value of free labor costs, provided the free employee is unpaid by the charitable organization that pays him. Such detailed treatment of unpaid labor in one exceptional case underscores the requirement that normally an expenditure is a precondition to reimbursement.

104. At one point, Petitioner argued that it is a related organization with the State of Florida, so that it could take the state's costs for these employees. But the related-organization provisions do not work this way. CMS Pub. 15-1, § 1000 states:

> Costs applicable to services, facilities, and supplies furnished to the provider by organizations related to the provider by common ownership or control are includable in the allowable cost of the provider at the cost to the related organization. However, such cost must not exceed the price of comparable services, facilities, or supplies that could be purchased elsewhere. The purpose of this principle is two-fold: (1) to avoid the payment of a profit factor to the provider through the related organization (whether related by common ownership or control), and (2) to avoid payment of artificially inflated costs which may be generated from less than arm's-length bargaining.

105. The sole purpose of this provision is to prevent a provider from using a related-organization transaction to inflate the provider's costs. This provision does not allow a provider receiving free labor from borrowing the labor costs of the organization employing the employee and using the organization's costs to build the provider's per diem cost base. As noted above, the sole provision allowing for an imputed cost for free labor involves employees who themselves are unpaid.

106. In the face of the dubious authority cited by Petitioner is the recurrent theme of the Plan, which is for the reimbursement of covered expenses actually incurred by the provider.

107. Thus, the reimbursement of $15,417 ($5,139 per cluster times 3 clusters) is an overpayment subject to recoupment by Respondent.

VII. Disallowed Transportation Costs and Airplane Costs

108. For the reasons noted in the Findings of Fact, the $123,848 in transportation salaries and benefits is allowable. It has nothing to do with the aircraft expenses that Respondent was trying to disallow.

109. The remaining expenses under this section raise an issue concerning the requirements and effect of a prima facie case. All of the findings and conclusions concerning all of the

cost items in these cases, except for the remaining aircraft expenses, would be the same, regardless of which party bore the burden of proof. The remaining aircraft expenses, alone, are or are not allowable, depending on which party bears the risk of nonpersuasion. The reason for this is the undeveloped state of the record concerning these expenses, as noted in the Findings of Fact.

110. The benefit of a prima facie case is the reward for a lawful audit. The auditing agency may not simply write down numbers on an examination report and claim this benefit, which transfers the burden of going forward with the evidence from the party with the affirmative of the issue (Respondent) to the defending party (Petitioner). GAAS requires the auditor "to obtain sufficient appropriate audit evidence . . . to afford a reasonable basis for an opinion . . .." If the "informative disclosures are not reasonably adequate," GAAS requires the auditor to disclose this fact. Section 409.913(20) underscores the requirements of identification and analysis that must support an audit report.

111. When these critical requirements are met, the examination report becomes a marker of sufficient reliability to shift the burden of going forward with the evidence from the party with the affirmative of the issue to the provider. Here, Respondent's examination report failed to earn this measure of

deference, at least in terms of its treatment of the aircraft expenses. Whether correct or not in his guesswork, Respondent's staff auditor does not discharge his responsibility by identifying aircraft expenses on an uninformed basis. Regardless of the characterization of the identification effort, the analysis of these expenses was nonexistent. Confronted with noncompliance, Respondent may issue an examination report documenting the noncompliance and pursue other remedies, such as the suspension of the provider from the Medicaid program. Cf. 42 CFR § 413.20 (Medicare). But Respondent may not transform the examination report into an unexamined set of mere allegations, at least without losing the benefit of the prima facie case that attaches to a duly prepared examination report.

112. Unable to secure the benefit of the prima facie case, as to the remaining aircraft expenses, the record is insufficiently developed to determine that these expenses were not allowable.

113. Thus, the reimbursements of these transportation and aircraft expenses are not overpayments.

RECOMMENDATION

Based on the foregoing, it is

RECOMMENDED that the Agency for Health Care Administration enter a Final Order determining that, for the 2001-02 cost-reporting year, Petitioner has been overpaid $23,370 (including

$3,418 for return on equity, if not already settled), for which recoupment and a recalculation of Petitioner's per-diem reimbursement rate are required.

DONE AND ENTERED this 25th day of April, 2011, in Tallahassee, Leon County, Florida.

____
ROBERT E. MEALE
Administrative Law Judge
Division of Administrative Hearings
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Filed with the Clerk of the
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this 25th day of April, 2011.

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NOTICE OF RIGHT TO SUBMIT EXCEPTIONS

All parties have the right to submit written exceptions within 15 days from the date of this Recommended Order. Any exceptions to this Recommended Order should be filed with the agency that will issue the Final Order in this case.