STATE OF NEW YORK
DEPARTMENT OF HEALTH

In the Matter of the Appeal of **Nesconset Center for Nursing and Rehabilitation** Medicaid Provider #02994856, from a determination to recover Medicaid Program overpayments.	**Decision After Hearing** #15-4992

Before: John Harris Terepka
Administrative Law Judge

By videoconference
December 10, 2020; February 10, March 16, 2021
Record closed November 15, 2021

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JURISDICTION

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

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

The OMIG objected that the Appellant "has no standing to challenge the final audit report in this matter" because in 2019 Nesconset Center for Nursing and Rehabilitation changed ownership between the issuance of the draft and final audit reports, and the hearing request was made, according to the OMIG, by the prior owner. (OMIG brief, pages 13-15, 44-45.) The OMIG's "standing" argument is unintelligible.

The OMIG's 18 NYCRR 517.3(c) notification was sent to and stated an intent to audit Nesconset Center for Nursing and Rehabilitation, Medicaid Provider #02994856, at 100 Southern Boulevard, Nesconset, New York. (Exhibit 1.) The May 30, 2018 draft audit report was issued and sent to Nesconset Center for Nursing and Rehabilitation, Medicaid Provider #02994856, at 100 Southern Boulevard, Nesconset, New York. (Exhibit 4.) The April 30, 2019 final audit report was issued and sent to Nesconset

Center for Nursing and Rehabilitation, Medicaid Provider #02994856, at 100 Southern Boulevard, Nesconset, New York. (Exhibit 6.)

> A person is entitled to a hearing to have the department's final determination reviewed if the department... requires the repayment of an overpayment or restitution. 18 NYCRR 519.4(a).
>
> Any clear, written communication to the department by or on behalf of a person requesting review of a department's final determination is a request for a hearing if made within 60 days of the date of the department's written determination. 18 NYCRR 519.7(a).

The May 8, 2019 hearing request was made by an attorney on behalf of Nesconset Center for Nursing and Rehabilitation, Medicaid Provider #02994856. (Exhibit 7.) The May 31, 2019 hearing notice was sent to Nesconset Center for Nursing and Rehabilitation, Medicaid Provider #02994856, at 100 Southern Boulevard, Nesconset, New York. (Exhibit 8.) The same attorney who made the hearing request appeared and represented Nesconset Center for Nursing and Rehabilitation at this hearing. No one else has appeared claiming to represent the interests of Nesconset Center for Nursing and Rehabilitation with respect to this audit, and the OMIG has produced no evidence from whoever it claims is the party that had standing in this matter that suggests the hearing request was not made on behalf of this Medicaid provider.

The OMIG's position that "no overpayment is being required from [the previous owner]" (OMIG brief, page 44) does not obviate the submission, "by or on behalf of" Nesconset Center for Nursing and Rehabilitation, Medicaid Provider #02994856, of a "clear, written communication to the department... requesting review of a department's final determination."

The OMIG invokes a Suffolk County Supreme Court decision filed on June 14, 2021 (Index #617154/2019) "wherein the court found that the [prior owner] did not have

standing to pursue a proceeding to compel Medicaid payments." (OMIG brief, page 15.) What past or current owner of this proprietary nursing home may ultimately bear the burden of any overpayment is outside the scope of this administrative proceeding, which concerns whether there is an overpayment to Nesconset Center for Nursing and Rehabilitation, Medicaid Provider #02994856.

HEARING RECORD

OMIG witnesses:	Babu Jacob, OMIG chief medical facilities auditor
OMIG exhibits:	1-27
Appellant witnesses:	[redacted] CPA [redacted] Esq. [redacted]
Appellant exhibits:	E-Z, AA

A transcript of the hearing was made. (Transcript, pages 1-325.) The record closed upon the submission of post-hearing briefs on November 15, 2021.

SUMMARY OF FACTS

1. Appellant Nesconset Center for Nursing and Rehabilitation is a proprietary residential health care facility, or nursing home, in Nesconset, New York and is enrolled as a provider in the Medicaid Program. In addition to the nursing home, it operates two adult day health care (ADHC) programs.

2. Auditors from the OMIG reviewed the Appellant's reimbursement from the Medicaid Program for the period February 1, 2008 through December 31, 2014. The Appellant's Medicaid reimbursement during this period was based upon its cost report for the period February 1, 2008 through January 31, 2009 base period and on subsequent cost reports for the calendar years January 1, 2009 through December 31, 2012. (Exhibit 6.)

3. On April 30, 2019, the OMIG issued a final audit report (#15-4992) that identified several disallowances of reported costs. The OMIG advised the Appellant that

these findings had resulted in a determination to recover Medicaid Program overpayments in the amount of $4,591,964. (Exhibit 6.) By letter dated May 8, 2019, the Appellant requested this hearing to review the overpayment determination. (Exhibit 7.)

4. Final audit report findings at issue in this hearing are:

Operating expenses:
a. Reclassification and/or disallowance of reported expenses relating to utilization review. (NF operating adjustment 1.)
b. Physicians services costs disallowance. (NF operating adjustment 4; ADHC I&II operating adjustment 2.)

Property expenses:
a. Mortgage expense disallowances. (NF and ADHC I&II property adjustment 1.)
b. Working capital interest disallowances. (NF property adjustment 5, attachment E1; adjustment 3, attachment E-2; ADHC I&2 property adjustment 4.)

ISSUE

Has the Appellant established that the OMIG's audit adjustments were not correct?

APPLICABLE LAW

A residential health care facility (RHCF) can receive reimbursement from the Medicaid Program for costs that are properly chargeable to necessary patient care. 10 NYCRR 86-2.17. As a general rule, these kinds of costs are reimbursable if they are actually incurred and the amount is reasonable. Reimbursable costs include operating expenses such as employee wages and benefits for administration and patient care, supplies, maintenance and utility costs. 10 NYCRR 86-2.10(a)(7). They can also include property costs such as depreciation, leases and rentals, insurance and necessary interest on both current and capital indebtedness. 10 NYCRR 86-2.10(a)(9), 86-2.19, 86-2.20, 86-2.21. Allowable costs shall not include expenses or portions of expenses reported by individual residential health care facilities which are determined by the Commissioner

not to be reasonably related to the efficient production of service because of either the nature or amount of the particular item. 10 NYCRR 86-2.17(d).

The facility is reimbursed by means of a per diem rate established by the Department on the basis of costs reported by the facility. PHL 2808; 10 NYCRR 86-2.10. The rate is provisional and subject to audit. The facility is required to prepare and to maintain contemporaneous records demonstrating its right to receive payment, to keep all records necessary to disclose the nature and extent of services furnished, and to furnish records to the Department upon request. 18 NYCRR 504.3(a). If an audit identifies errors in the provisional rate, the Department can retroactively adjust the rate. SSL Section 368-c; 10 NYCRR 86-2.7; 18 NYCRR 517.3. The Department may then require the repayment of any amounts not authorized to be paid under the Medicaid Program. 18 NYCRR 518.1.

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

DSS regulations pertinent to this hearing are found at 18 NYCRR Parts 517, 518 and 519, and address the audit, overpayment and hearing aspects of this case. Specific Medicaid reimbursement rules pertinent to this hearing are addressed by Department of Health regulations at 10 NYCRR Part 86-2, which concerns reporting and rate certifications; Part 452, which outlines basic concepts, reporting principles and specialized reporting areas for nursing home cost reports; Parts 454 and 455, which describe functional reporting; and Part 456, which sets forth cost-finding practices and

procedures. Also applicable, unless otherwise provided in Part 86-2, are the principles of reimbursement developed for determining payments under the Medicare Program. 10 NYCRR 86-2.17(a). These are primarily found at 42 CFR chapter IV, and in the Medicare Provider Reimbursement Manual, Part I (PRM-I).

DISCUSSION

General objections.

The Appellant raised several objections to the OMIG's overpayment determination that are not based on specific audit report disallowances:

Universal Settlement. In December 2015 the Department reached agreement with most of the nursing homes in New York in order to resolve issues regarding base years for reimbursement. (Exhibit 27; OMIG brief, page 36.) The Appellant makes various arguments to the effect that the "universal settlement" precludes adjustments made in this audit. (Appellant brief, pages 10-13.)

The universal settlement only covered certain costs for certain years. In this audit, the OMIG auditors did not adjust the 2011 property rates because they were based upon a 2009 cost report which was not attributable to a change in ownership. (Transcript, pages 116-126.) Other costs, however, can still be audited.

The Appellant's account of the Settlement Agreement, which is a complex document, is selective and misleading. The Appellant's brief sets forth in their entirety Sections 12.1, 12.2 and 12.4 of the agreement, which address in general terms matters discontinued under the agreement, but omits Section 12.3 and 12.5. Section 12.3 states:

> 12.3. OMIG reserves the right to: (i) Review, investigate and/or audit any of the categories of rate appeals or litigation excluded by Sections 9 and 10 of the Settlement Agreement, respectively. (Exhibit 27, Section 12.3.)

The Appellant fails even to mention Section 9, on which the OMIG relies, which excludes appeals of ADHC rates (9.1), capital component rates related to changes in ownership (9.3) and rate appeals for initial base year operations (9.7). (Exhibit 27, Section 9.) This nursing home did change ownership in 2008, as a result of which a new cost report was submitted. The December 2015 agreement also excluded pending audits not specifically listed in the agreement. (Exhibit 27, Section 12.5.) The list does not include this audit, noticed on September 21 and begun on November 12, 2015. (Exhibits 1, 2.) 18 NYCRR 517.3(c)&(f). The Appellant did not attempt to explain why these are not precisely the exclusions the OMIG says they are. (OMIG brief, pages 36-38.) The Appellant has failed to establish that any adjustments or overpayments identified in this audit were precluded by the "universal settlement."

Rate Appeals. The Appellant claims it has several pending rate appeals that may impact its reimbursement during the rate periods at issue. (Appellant brief, pages 13-14; Transcript, pages 213-14.) According to the Appellant the OMIG was required by Section 12 of the Settlement Agreement to incorporate pending rate appeals in the audit. (Transcript, pages 14, 17; Appellant brief, page 12.) Section 12 does not require that. (Exhibit 27, page 798.) The Appellant further argues that pursuant to SSL 368-c(2) the OMIG must integrate all positive rate appeals, whenever taken, into the audit findings before it can recover any overpayments. (Transcript, pages 18-19.) SSL 368-c does not require that.

The Appellant's suggestion (Appellant brief, pages 13-14) that the Department's obligation to identify "appropriate rates of payment" means no audit adjustment can be made with regard to any issue unless it is part of an overall resolution of all existing

reimbursement issues between the facility and the Department – including appeals that the Appellant itself points out "the OMIG itself may not have the authority to process" - is rejected. There may be a number of different reviews of a facility's Medicaid reimbursement at various stages at any one time. They can include rate appeals that are taken and may be pending at the time of an audit. 10 NYCRR 86-1.32. Rate appeals are not under review in this audit nor may they be reviewed in this administrative hearing. 18 NYCRR 519.18(a). Some of the appeals the Appellant wants incorporated into this audit, particularly regarding working capital costs, were initiated after the audit was completed. (Transcript, pages 132-33.)

Nor does the Department's obligation to identify "appropriate rates of payment" require or even authorize the OMIG to, as the Appellant suggests, review and overturn the Department's Bureau of Long Term Care Reimbursement (BLTCR) rate setters on such matters as whether to recognize a particular mortgage as reimbursable. (Transcript, pages 211-212; Appellant brief, pages 31-33.)

The Appellant's assertion "the audit is of the rates, not of the cost report." (Transcript, page 212) does not advance its argument. An 18 NYCRR Part 517 audit unambiguously "applies to fiscal audits and reviews of a provider's claims, books, records, reports or other available documentation... which are used for the purpose of establishing rates of payment." 18 NYCRR 517.1(a), 517.3(a)(1). The OMIG is entitled to look at reported costs and verify their accuracy, and a "rate audit" such as the one under review herein is simply an audit of the documentation to support those reported costs. The Appellant's argument "when you do a rate audit, you open up the rate and when you open up the rate, you open up all the costs upon which that rate is based"

(Transcript, page 20) is meaningless if "open up the rate" is intended to convey anything more than when reported costs are corrected on audit, the rate may be retroactively adjusted. SSL 368-c; 10 NYCRR 86-2.7; 18 NYCRR 517.3(a).

Scale back. The Appellant asserted in its response to the draft audit report that a "scale back," in which the Department performed an across-the-board reduction of Medicaid reimbursement to New York nursing homes, renders the recovery of the overpayments identified in this audit somehow duplicative. (Exhibit 5, page 79; Appellant brief, page 3.) The Appellant did not present evidence on this objection nor did it address it in its post hearing brief. It has offered no persuasive reason to conclude that a statewide across-the-board adjustment of rates for one reason – the "scale back" – necessarily means that an adjustment for another reason specific to this provider – this audit – is a "duplicative adjustment." (Transcript, pages 21-22.)

The OMIG auditor testified that the "scale back" was not relevant to the audit adjustments under review. (Transcript, pages 127-28.) This view is consistent with case law in which this issue has been settled. North Gate HCF v. Zucker, 174 A.D.3d 1201, 104 N.Y.S.3d 785 (3rd Dept. 2019). (OMIG brief, page 40.)

The audit adjustments.

Because this was an audit of the nursing home and two ADHC programs, the audit report allocated the adjustments among those programs. The allocation of costs between the programs is not at issue and need not be addressed in this decision. As the issues for each type of adjustment are the same, they can be addressed collectively for all three programs.

Operating adjustment 1: Utilization review. The Appellant reported $242,284 in salaries and benefits for three positions on "schedule h" of its cost report in the utilization review cost center 20. PHL 4900(8); 10 NYCRR 455.20. (Exhibit 13, page 311; Transcript, pages 51-53, 281-84.)

The OMIG did not disallow these employee salaries and benefits. The OMIG verified and accepted that they were paid, and that these expenses were properly includible on the facility's cost report. (Transcript, page 52.) The issue is where the costs can properly be recognized on the cost report. The audit determined the reported salaries did not belong in the utilization review cost center 20, and so moved them to the direct component of the rate and allowed them in nursing administration cost center 13. (Transcript, pages 64, 67.) The utilization review cost center is in the "noncomparable" component of the rate. 10 NYCRR 86-2.10(b); 86-2.40(x). The nursing administration cost center is in the "direct" component of the rate. 10 NYCRR 86-2.10(c). The Appellant's attempt to report the costs in the utilization review cost center effected an increase in its Medicaid reimbursement because it enabled the Appellant to avoid reimbursement ceilings that were applicable to the direct but not to the noncomparable component of the rate. 10 NYCRR 86-2.10(a)(10-12), (c)&(e). (Transcript, page 37.)

The Appellant was not over the reimbursement ceiling for direct costs for the entire period audited. The overpayment is attributable only to those rate periods in which its allowable direct costs were over the ceiling. During those periods in which the Appellant's adjusted direct costs remained within the reimbursement "corridor" the reclassification had no impact on reimbursement. (Transcript, pages 64-65, 224-25.)

The salaries reported as utilization review costs included the Appellant's Minimum Data Set (MDS) coordinator, social services director, and one or more other unidentified staff. (Transcript, pages 53, 157, 283-87; Exhibit 16, page 431.) Although the MDS coordinator's and social service director's job descriptions included duties other than utilization review, the Appellant reported the entirety of their salaries as utilization review costs. Other employees whose salaries and benefits were reported were not identified. (Transcript, pages 58-61, 156-57.)

The OMIG reclassified these salaries and benefits from the noncomparable to the direct component of the rate and assigned them to the nursing administration cost center because the job descriptions that were provided fit that cost center. Pursuant to 10 NYCRR 454.2(b)&(c), if an employee is performing activities related to more than one function, an allocation between cost centers must be supported by a time study justifying the allocation. The Appellant failed to substantiate the basis for allocating any portion of these salaries to utilization review. (Transcript, pages 157-58, 165.)

In May 2016, representatives from the Appellant met with auditors to discuss this disallowance and provided documents and job descriptions for the utilization review coordinator and the MDS coordinator. According to the position descriptions, the utilization review coordinator reported to the MDS coordinator. (Exhibit 25; Transcript, pages 58, 153.) No allocation of MDS coordinator or social service director duties between utilization review and any other cost center was made or documented. (Transcript, pages 60-61; Exhibit 25, pages 741-42.) No time studies as required by the regulation were performed or documented. (Transcript, pages 49-52, 57.)

[redacted] testified that she became the Appellant's utilization review coordinator in 2008 and "until 2009, some time, maybe '10." (Transcript, pages 267, 270.) According to the Appellant, the salary of [redacted] "as well as any administrative people that she discussed that worked with her" constituted the $242,284 reported for utilization review on schedule "h" of the cost report. (Transcript, page 281.)

Ms. [redacted] claimed utilization review was all she did (Transcript, page 271), and testified that she and an assistant were the ones involved in utilization review. She also testified:

> Q. Were there others involved as utilization review personnel?
>
> A. No, there was an interdisciplinary team with the rehab and social workers and staff nurses to prepare, you know, the services and coordinate. But it was with me. In that period of time that I did it, and after me, there may have been others. (Transcript, page 270.)

The Appellant failed to document or even offer a specific figure for Ms. [redacted] salary either during the audit or at this hearing. (Transcript, pages 281, 287.) The Appellant also failed to explain how her account squares with its inclusion of both the full salary of the MDS coordinator Ms. [redacted] reported to, and the full salary of the social services director, which the auditors determined to have also found their way into the $242,284 figure reported on the cost report. (Transcript, page 157.)

The Appellant suggested at the hearing that "I don't think it's pertinent" whether or how the reported figure adds up because "we have established that there was utilization review, and therefore, there's no disallowances that should be made against it." (Transcript, page 287; Appellant brief, page 26.) This view gets the concept of auditing backwards. The task of the auditor is not to accept and allow all reported utilization review costs because utilization review has been done. It is to verify the

reported costs in order to determine whether they were accurately reported and are allowable in connection with that function, and in what amount.

Rather than account for and allocate the specific salaries and benefits it included in the utilization review cost center, the Appellant instead complains "OMIG is applying an overly restrictive interpretation of the standard for what constitutes utilization review," and seeks a broad interpretation of utilization review to encompass nearly anything having to do with the quality and nature of patient services. (Appellant brief, pages 18-20.) Thus, the MDS process and social services, and so the entire salary of its MDS coordinator and social services director, become utilization review because "accurate MDS preparation drives the utilization of facility services and individual care needs determinations...." (Appellant brief, pages 20-21.) The Appellant also argues that because utilization review was a mandatory service and was provided, the facility is entitled to reimbursement for the costs it reported for it. (Appellant brief, pages 25-26.) These rationalizations are an inadequate substitute for accurate reporting and documentation of the actual costs for which the Appellant seeks reimbursement in the noncomparable component of its rate.

In September 2020, the Appellant presented additional documents that had not been produced for the audit, several of which document activity in 2020, not activity during the audit period. (Exhibits F-L.) The draft audit report, issued on May 30, 2018, had advised the Appellant to submit within 30 days any additional documentation to be considered in the audit. (Exhibit 4.) The Appellant did not submit this material purporting to justify an allocation until mid-2020, long after the audit was completed and

a final report issued. (Transcript, pages 160-62.) It is not relevant to this review of a completed audit and may not be considered in this hearing. 18 NYCRR 517.5; 519.18(a).

In any event, the belatedly submitted material did not document an allocation for the period covered by this audit. A "time study," prepared 12 years after the fact, did not conform to the requirements of 10 NYCRR 454.2(c), or otherwise justify classifying the entirety of the salaries of MDS coordinator and social service director to the utilization review cost center during the cost period under review. A utilization review coordinator's position description had the UR coordinator reporting, not to the MDS coordinator as documented in 2016 during the audit, but to the admissions director. (Exhibit G.)

The Appellant failed to establish that the OMIG's determination to reclassify costs from the noncomparable to the direct component of the rate was not correct.

Operating adjustment 4: Physicians services. The cost of services by physicians was an ancillary service that was not reimbursable to this Appellant in its Medicaid rate. This means that these costs should not have been included in the calculation of the rate. (Transcript, pages 70-72; Exhibit 18, page 504.) The auditors found that various physician services costs had been reported in other cost centers, as medical director and inhalation therapy costs. (Transcript, pages 74-80, 169, 177.) The auditors disallowed these reported costs because they were for physician services that are not includible in the Appellant's rate. (Transcript, pages 74-79, 170; Exhibit 16, page 442.) The Appellant offered no evidence at the hearing to meet its burden of proving this determination was incorrect and that the reported costs were allowable in the Appellant's rate, nor did it address this adjustment in its post hearing brief. The adjustment is affirmed.

Property adjustment 1: Mortgage expense disallowances. This nursing home changed hands on February 1, 2008. The seller's mortgage in existence at that time, for which Medicaid reimbursement had been approved, was paid off upon closing and so no longer existed after February 1, 2008. The new owners obtained a "bridge loan" upon acquiring the facility on February 1, 2008, and then, in 2011, the HUD mortgage that is its current financing. (Transcript, pages 204-205.)

After the February 2008 transfer, the Appellant continued to report, and until July 31, 2008 the Department mistakenly continued to reimburse, costs on the basis of the prior owner's mortgage. (Exhibit X; Transcript, pages 83-84, 251-52, 309-311.) This reimbursement received for the cost of the previous owner's mortgage from February through July 2008, a period when the mortgage no longer existed, was disallowed in this audit.

The Appellant's new financing, which began in February 2008 - first the bridge loan and then the HUD mortgage - did not meet Department guidelines and so was not approved or recognized by the BLTCR for Medicaid reimbursement. (Exhibit 15, page 399; Exhibit R; Transcript, pages 84, 87-88, 204-205.) As a result of these audit findings, the Appellant had no mortgage costs that were approved for Medicaid reimbursement during the audit period. Consequently, the Department determined to provide reimbursement based upon return of equity pursuant to 10 NYCRR 86-2.21(e)(4). (Transcript, pages 84-85, 179-180, 255-57.) The Appellant's own witness, its accountant [redacted] confirmed that this form of reimbursement was appropriate:

> Q. If the now *[sic]* loan is found not acceptable, does the facility still, in your experience, receive reimbursement?

A. They get return of equity, but they don't get any mortgage reimbursement. (Transcript, pages 221-22.)

The Appellant concedes that the mortgage reimbursement it actually received until July 2008 was for a mortgage that in fact no longer existed, and it does not argue that the bridge loan or HUD financing were ever approved by the BLTCR for Medicaid reimbursement purposes. To the contrary, Appellant witness [redacted] testified that the Appellant filed rate appeals seeking approval of the bridge loan and HUD financing, and that those appeals were either denied or are "still sitting in the system." (Transcript, pages 213-17.) Any such rate appeals are outside the scope of and are not reviewable in this audit, the purpose of which is to determine whether the costs reported on the Appellant's cost reports are accurate and reimbursable. 18 NYCRR 519.18(a).

[redacted] an attorney who had represented the Appellant in the 2008 and 2019 purchase transactions but not the related certificate of need (CON) applications (Transcript, pages 241-42), opined that since the Department granted a CON that authorized the transfer in 2008, and because that purchase required financing:

> ... the Department has accepted the loan... I don't see how they could have given the CON approval without having reviewing *[sic]* the loan and determined that it met their appropriate guidelines. (Transcript, page 247.)

According to the Appellant, this means its financing was "pre-approved by DOH." (Appellant brief, page 33.) This claim is not supported either by its own argument or by the evidence it relies on. (Exhibits Y, Z, AA.) All the Appellant has asserted is that the Department's Public Health Council "knew of and approved" that it was intending to obtain financing in connection with the proposed purchase. The Appellant goes on to concede: "Of course, the specifics as to the terms of the financing as to principle *[sic]* borrowing limits, rate, and term of repayment were all subject to later consideration and

approval, a process which should have taken place at the time of audit." (Appellant brief, page 33.) Department of Health BLTCR approval of mortgage financing is not a process which can or should take place in an OMIG 18 NYCRR Part 517 audit of reported costs.

The Public Health Council's January 16, 2008 approval of the purchase specifically states:

> Public Health Council approval is not to be construed as approval of property costs or the lease submitted in support of the application. Such approval is not to be construed as an assurance or recommendation that property costs or lease amounts as specified in the application will be reimbursable under third-party payor reimbursement guidelines. (Exhibit AA.)

The approval contingencies included submission of a mortgage commitment acceptable to the Department. (Exhibit Z, page 4.) The proposed Greystone financing on which the Public Health Council granted its approval (Exhibit Y, page 7) was not the financing that the Appellant actually obtained. Instead, the Appellant obtained the bridge loan and then in 2011 the HUD financing. (Transcript, pages 318-19.) Neither the bridge loan nor the HUD financing was ever approved by the Department as reimbursable.

The Appellant also suggests that even though approval of its financing has been denied, if it paid any capital financing costs it is still entitled to and must be reimbursed for them. (Appellant brief, pages 29-30.) It argues:

> The appeal denials by DOH of the bridge loan... or the HUD... permanent mortgage financing... only acted as disapproval of the specific terms of the respective financing arrangements, not the reimbursement of any or all interest and amortization. (Appellant brief, page 31.)

Disapproval of its proposed financing arrangements hardly meant the Appellant then became entitled to "any or all interest and amortization" from any other arrangements it might decide to make. The Appellant claims "both the 2008 bridge loan and 2011 HUD loans met the regulatory requirements for reimbursement." (Appellant brief, page 31.)

They did not, because they were not approved by the Department for reimbursement. 10 NYCRR 86-2.20(e). That is why, as Appellant witness [redacted] explained, "they get return of equity, but they don't get any mortgage reimbursement." (Transcript, page 222.)

The Appellant nevertheless seeks reimbursement for interest costs on the bridge loan from February 2008 until the HUD mortgage financing was obtained in 2011, and interest and amortization on the HUD financing from 2011 through the end of the audit period, up to the amount of the originally approved historical cost of the facility. (Transcript, pages 259-63; Appellant brief, page 35.) Mr. [redacted] alleged that in circumstances such as were presented in this case, the Department has had a "historical policy" of reimbursing "up to the amount that would have been paid had the original mortgage been in effect." The Appellant's claim that this disallowance "did not appear to be in line with DOH historic policy" (Appellant brief, page 32) relied on assertions by Mr. [redacted] about "many department announcements over the years" that he then admitted he was unable to substantiate. (Transcript, pages 247-51.)

The Appellant's suggestion that it is entitled to reimbursement for an unapproved mortgage up to the approved historical cost of the facility is, as [redacted] testified, contrary to the explicit regulatory policy set forth at 10 NYCRR 86-2.21(e)(4) and applied in this audit. The claimed "historical policy" of recognizing new financing up to historical cost would still require approval of that new financing, a condition that was not met here. Neither the bridge loan nor the subsequent HUD financing was ever recognized by the Department for Medicaid reimbursement. 10 NYCRR 86-2.21(a)(1)(iii).

The Appellant failed to establish that it is entitled to be reimbursed, not in accordance with 10 NYCRR 86-2.21(e)(4), but instead either on the basis of a non-existent mortgage or for the cost of financing that was not approved for Medicaid reimbursement. The mortgage costs disallowed in this audit were properly disallowed because they were not incurred, or to the extent that they were incurred were not costs of financing for which the Appellant had secured the required approval. The audit adjustments are affirmed.

Property adjustment 5: Working capital interest expense. The Appellant's new owner purchased the previous owner's accounts receivable upon the transfer of ownership on February 1, 2008 by executing a note agreeing to pay for the purchase in three installments ending in 2012. (Transcript, pages 105-106; Exhibit 26, page 755.) No principal payments were required during the cost period, but the Appellant reported interest on the note as working capital interest expense. Principal payments were not required to begin for two years after the transfer. (Exhibit 26, pages 749, 755.)

Necessary interest on both current and capital indebtedness is an allowable cost for RHCFs. 10 NYCRR 86-2.20(a). It does not follow from this, as the Appellant would have it, that because "DOH regulations expressly allow interest expense of this nature to be paid" (Appellant brief, page 36), that the Appellant is entitled to be paid for whatever cost it reported as working capital interest expense.

The OMIG concluded that in this instance the interest reported is not reimbursable by Medicaid as either current or capital indebtedness. It is not capital indebtedness because it does not qualify as such under 10 NYCRR 86-2.20(e). It is not current indebtedness under 10 NYCRR 451.71 and PRM-1 202.1 because it was not to be paid

within a year or any other relatively short period. Furthermore, an interest only loan does not qualify as short-term debt because if no principal payments are made the loan is indefinite in period and there is no realistic expectation the debt will be paid off within a year or similarly short period as required under 10 NYCRR 451.71 and PRM-1 202.1. (Transcript, pages 184-87.)

The OMIG auditors also concluded that this was not a working capital loan incurred for day-to-day operations. To be reimbursable, working capital indebtedness must be short term for operating costs. The Appellant suggested that if it purchased the previous owner's accounts receivable for the purpose of obtaining cash flow, the debt it incurred to do so was in effect borrowing incurred for short-term operating costs. The Appellant did not explain why it was desirable or appropriate and reasonably related to necessary patient care to obtain short-term working capital financing in this roundabout way. No funds were actually advanced to the Appellant or made directly available to it in connection with its execution of the note. Whatever funds were obtained would have to be collected by the Appellant from the account debtors, not the seller to whom it gave the note. The OMIG's auditor rejected the Appellant's rationale, denying the transaction constituted a short-term loan and characterizing it instead as what it in fact was: "buying an asset, account receivable is an asset." (Transcript, pages 186-87.)

The auditors' conclusions that the Appellant's purchase of accounts receivable was not short-term financing of operating costs and that it was financing of the purchase of an asset, are rational and consistent with the applicable regulations. The OMIG is within its regulatory authority in making this audit determination and the disallowance is affirmed.

The Appellant's further argument that this reimbursement was allowed as a "judgment by the rate setters" and so cannot be overturned by an audit adjustment in a Part 517 audit of costs (Appellant brief, pages 36-37) is rejected. This is precisely the argument the Appellant ignores in property adjustment 1 by asking this OMIG audit to overturn the Department's BLTCR and allow mortgage financing it disapproved for Medicaid reimbursement. For this property adjustment 5, the Appellant asks the OMIG to abide by an alleged determination the Department rate setters never made. The argument was invalid with regard to the mortgage financing and it is invalid here.

The rate was paid based upon reported but unaudited costs. It is precisely the purpose of this Part 517 audit to review and verify those reported costs. The rate setters did not review the Appellant's documentation (Exhibit 26) and determine that its purchase of accounts receivable from a previous owner, with "interest only" financing, qualified as working capital indebtedness. Nor did the OMIG auditors determine that the Appellant is not entitled to be reimbursed for interest on working capital indebtedness. The audit determination, which is not a rate setting determination, is that the reported interest did not, on audit, prove to qualify as working capital interest expense. Daughters of Sarah N.C. v. Novello, 69 A.D. 3d 1150, 894 N.Y.S.2d 541 (3rd Dept 2010.)

The auditors also disallowed this working capital interest as reported for 2012 because the facility made a profit and the owners made equity withdrawals in that year. (Property expense adjustment 3, Exhibit 6, page 134.) Short-term borrowing necessitated because of equity withdrawals is not reimbursable. (Exhibit 26, page 781; Transcript, pages 107-108, 112-13, 218-19.) This additional grounds for disallowing the reported cost for 2012 is also affirmed.

DECISION: The operating expense disallowances attributable to utilization review are affirmed.

The operating expense disallowances attributable to physicians services are affirmed.

The property expense disallowances attributable to mortgage expense are affirmed.

The property expense disallowances attributable to working capital interest expense are affirmed.

The overpayment determination is affirmed.

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

DATED: Rochester, New York
December 1, 2021

John Harris Terepka
Administrative Law Judge