# PROVIDER SERVICES, INC. – TAKODA TRAILS
# BUTLER COUNTY
# INTERMEDIATE CARE FACILITY

## AGREED UPON PROCEDURES

## FOR THE COST REPORTING PERIOD
## JANUARY 1, 2011 THROUGH DECEMBER 31, 2011

Dave Yost • Auditor of State

**PROVIDER SERVICES, INC. – TAKODA TRAILS**
**BUTLER COUNTY**

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**Independent Auditor's Report on Applying Agreed-Upon Procedures**

Mr. Chris Carson, Bureau Chief
Bureau of Audit Performance
Ohio Department of Medicaid
50 W. Town Street, 5th Floor
Columbus, Ohio 43215

Dear Mr. Carson:

As required by Ohio Rev. Code § 5111.27 and Ohio Admin. Code § 5101:3-3-20, the Auditor of State's Office performed the procedures enumerated below to which the Ohio Department of Medicaid (ODM) also agreed. These procedures are designed to assist you in evaluating whether Provider Services, Inc. – Takoda Trails (hereafter referred to as the Provider) prepared its JFS 02524 ICF-MR Medicaid Cost Report (Cost Report) for the period January 1, 2011 through December 31, 2011 in accordance with the Medicaid Cost Report Instructions and the Appendix to Ohio Admin. Code § 5101:3-3-71.1 (Cost Report Instructions) and to assist you in evaluating whether reported transactions complied with CMS Publication 15-1, and other compliance requirements described in the procedures below. Note that all rules and code sections relied upon in this report were those in effect during the period ending December 31, 2011 and may be different from those currently in effect. The Provider's management is responsible for preparing these reports. This agreed-upon procedures engagement was conducted in accordance with the American Institute of Certified Public Accountants' attestation standards. The sufficiency of these procedures is solely the responsibility of ODM. Consequently, we make no representation regarding the sufficiency of the procedures described below either for the purpose for which this report has been requested or for any other purpose.

**Occupancy and Usage**

1. ODM requested that we report variances if the Provider's inpatient days were greater than those reported on *Schedule A-1, Summary of Inpatient Days*.

   We compared the Provider's inpatient days on the Yearly Census by Payer Report for the number of patient days for Medicaid and non-Medicaid patients to those reported on *Schedule A-1*. We also footed the reports for accuracy.

   We found no variances where inpatient days were greater than reported.

2. ODM requested that we report variances if total Medicaid inpatient days and total inpatient days were greater than those reported on *Schedule A-1, Summary of Inpatient Days* for one month.

   We compared the Medicaid inpatient days and total inpatient days reported on *Schedule A-1* for December 2011 with the total of the Detailed Census Report by Payer report for Medicaid inpatient days and total inpatient days. We also footed the reports for accuracy.

   We found no variances where inpatient days were greater than reported for the month. However, we noted 9 hospice days reported under authorized Medicaid days instead of Veterans and Other Days.

   We reported these variances in Appendix A.

**Occupancy and Usage (Continued)**

3. ODM requested that we report variances to *Schedule A-1, Summary of Inpatient Days* if total inpatient days were greater than those reported for one month.

   We haphazardly selected six residents' medical records and compared the total days the resident was in the Provider's care for December 2011 with the total inpatient days reported on the Detailed Census Report by Payer report and *Schedule A-1*. For the selected individuals we also determined if the Provider included any waiver respite days as Medicaid or Medicare days and if bed hold days in excess of 30 in a calendar year received the proper authorization on form JFS 09402 in accordance with Ohio Admin. Code § 5101:3-3-16.8.

   We found no variances where inpatient days were greater than reported for the month and no misclassified waiver respite days or unauthorized bed hold days.

4. ODM requested that we report variances if the Provider had reimbursed Medicaid days in excess of total Medicaid days reported on *Schedule A-1, Summary of Inpatient Days*.

   We compared the number of reimbursed Medicaid days per the Medicaid Information Technology System (MITS) with the total Medicaid days reported on *Schedule A-1*.

   We found that total Medicaid days reported exceeded Medicaid reimbursed days per MITS.

**Medicaid Paid Claims**

ODM requested that we select paid claims for three Provider residents in one month and report any variances if the claims did not meet the applicable documentation requirements.

We selected all paid claims for three Provider residents for the month of December 2011 from MITS and compared the reimbursed Medicaid days to the days documented per the resident's medical records. We determined if the Provider's documentation met the general requirements of CMS Publication 15-1, Chapter 23, and Ohio Admin. Code § 5101:3-3-20 and if the days billed met the specific requirements of Ohio Admin. Code § 5101:3-3-16.8(C) to (E) as an occupied or bed hold day and Ohio Admin. Code § 5101:3-3-39 for the payment adjustment requirements for resident's discharge, admittance to hospital, death or election to receive hospice care.

We found no instances of non-compliance with these documentation requirements.

**Non-Payroll Expenses**

1. ODM requested that we compare the Provider's non-payroll expenses to the amounts reported on *Schedule B-1, Other Protected Costs; Schedule B-2, Direct Care Cost Center;* and *Schedule C, Indirect Cost Care Center* and report reclassifications between schedules and adjustments resulting in decreased costs exceeding five percent of non-payroll expenses on any schedule.

   We compared all non-payroll expenses reported on *Schedule B-1, Schedule B-2* and *Schedule C* to the Provider's General Ledger Account Analysis and General Ledger Trial Balance reports to identify variances exceeding five percent of non-payroll expenses on any schedule.

   We found no differences exceeding five percent on any one schedule.

**Non-Payroll Expenses (Continued)**

2. ODM requested that we select a sample of 20 non-payroll expenses reported on *Schedule B-1, Other Protected Costs; Schedule B-2, Direct Care Cost Center; Schedule C, Indirect Cost Center;* and *Exhibit 3, Home Office Trial Balance* and report expenses exceeding $500 which lacked supporting documentation, or were not properly allocated or were unallowable.

   We haphazardly selected 20 non-payroll expenses from non-payroll accounts on *Schedule B-1, Schedule B-2,* and *Schedule C*. We reviewed these expenses to determine if they had supporting documentation, were properly allocated and classified, and were allowable expenses per the Cost Report Instructions, Ohio Admin. Code § 5101:3 and CMS Publication 15-1.

   We found variances exceeding $500 as reported in Appendix A.

3. ODM requested that we review the allocation methodology used in the Provider's Home Office Allocation schedule allocating costs on *Schedule B-1, Other Protected Costs; Schedule B-2, Direct Care Cost Center; Schedule C, Indirect Cost Care Center;* and equity on *Schedule E-1, Return on Equity Capital of Proprietary Providers* and determine if it was reasonable, allowable, related to residential care, and properly classified in accordance with Ohio Admin. Code § 5101:3, CMS Publication 15-1, Section 2150 and the Cost Report Instructions. ODM requested that we report any reclassifications between schedules and adjustments resulting in decreased Home Office costs on any schedule.

   We did not perform this procedure for Home Office expenses since the Provider did not report these costs on *Schedule B-1, Schedule B-2, Schedule C* or *Schedule E-1*. However, we did review the allocation methodology for $393,863 in Indirect Consulting and Management expenses reported on *Schedule B-2* and *Schedule C.*

   We noted that the contract with the management company for Indirect Consulting and Management expenses reported on *Schedule B-2* and *Schedule C* was based on 6 percent of net revenues per month. CMS Publication 15-1, Section 2102 states "Implicit in the intention that actual costs be paid to the extent they are reasonable is the expectation that the provider seeks to minimize its costs and that its actual costs do not exceed what a prudent and cost-conscious buyer pays for a given item or service. If costs are determined to exceed the level that such buyers incur, in the absence of clear evidence that the higher costs were unavoidable, the excess costs are not reimbursable under the program."

   Furthermore, we noted that the same management company charged only 2 percent of net revenues per month to another intermediate care facility for the same services according to both contracts. Therefore, we reclassified the excess costs above 2 percent as non-federal reimbursable as reported on Appendix A.

   **Officials' Response**: Your report noted that the management fees were not reasonable and prudent based on the fact that they were billed based on a percentage of the provider's revenue. You noted that PRM 15-1 does not allow for the use of revenue as an allocation basis for home office costs. However, the provider and management company are not related parties, and the management fees are therefore not considered home office costs. A percentage of revenue is an allowable basis (and common practice in the industry) for determining the fees charged to the provider.

**Officials' Response (Continued)**:

The percentage of revenue basis is a widely accepted in management fee agreements in the long-term care industry. In this case, there is no "allocation" based on revenue, rather there is a charge based on revenue which is the most common way in which the industry assesses management fees. Further, we provided you with support from the 2011 Medicaid cost report database (which included an analysis of all 148 facilities in the same peer group) that the providers' management fees were well within the amount of management fees reported by other providers.

Therefore, we believe the management fees as reported were reasonable and allowable, and that adjustments related to the management fees should be removed from the audit report.

***Auditor of State's Conclusion*:** Our draft report dated September 26, 2014 indicated that we did not have sufficient documentation to determine if management fees were allocable in relation to the benefits received, reasonable, and charged by the Provider at the cost the related management organization incurred to provide the services. We received additional documentation from the Provider showing the management company was a separately controlled entity and, correspondingly, that there was no issue with allocation of the management fees based on revenue. However, we still conclude that these management fees were not reasonable or prudent based on the same management company charging only two percent of net revenues per month to another intermediate care facility for the same services according to a comparison of both contracts.

CMS Publication, 15-1, Section 2135.3 (D)(1) states that the determination of the reasonable costs of purchased management and administrative support services should be evaluated by taking "The cost of contracts providing for a package of services, such as a full service management contract, will be compared if possible against a comparable package of services…" In addition, Section 2102 as mentioned above also states, "…If costs are determined to exceed the level that such buyers incur, in the absence of clear evidence that the higher costs were unavoidable, the excess costs are not reimbursable under the program."

In addition, we did not perform procedures as part of this engagement to review the management/consulting fees or home office costs of all the facilities used in the reasonableness analysis provided by the Provider's independent accounting firm. Therefore, we do not know the nature and extent of those packages of services and if they were comparable to those services provided by the Provider's management company. With no clear justification of the higher costs, we reclassified the excess costs above two percent as non-federal reimbursable as reported on Appendix A.

4. ODM requested that we scan the Provider's non-payroll expenses reported on *Schedule B-1, Other Protected Costs; Schedule B-2, Direct Care Cost Center;* and *Schedule C, Indirect Cost Center* for nonfederal reimbursable costs or costs not properly classified exceeding $500 or contractor costs over $10,000 that should have been reported on *Schedule C-3, Costs of Services from Related Parties*.

   We scanned the Provider's General Ledger reports for non-payroll expenses exceeding $500 reported on *Schedule B-1, Schedule B-2,* and *Schedule C* to determine whether these costs are non-federal reimbursable costs or costs not classified in accordance with Ohio Admin. Code § 5101:3, CMS Publication 15-1, and the Cost Report Instructions. We also scanned for any contractors which would require reporting on *Schedule C-3*.

   We found no differences exceeding $500. We found no contracts which should be reported on *Schedule C-3*.

**Non-Payroll Expenses (Continued)**

5. ODM requested that we compare the 2011 non-payroll costs reported on *Schedule B-1, Other Protected Costs; Schedule B-2, Direct Care Cost Center;* and *Schedule C, Indirect Cost Care Center* by chart of account code to non-payroll costs reported by chart of account code in 2010 and obtain the Provider's explanation for non-payroll variances that increased by more than five percent and $500 from the prior year's schedules and report adjustments exceeding $500 and five percent of non-payroll costs on any schedule.

   We compared the 2011 non-payroll costs reported on *Schedule B-1, Schedule B-2,* and *Schedule C* by chart of account code to non-payroll costs reported by chart of account code in the prior year and obtained the Provider's explanation for eight non-payroll variances.

   The Provider stated that the increase in real estate taxes on *Schedule B-1* was due to reporting errors in the prior year. The Provider stated that the increases in Other Direct Care and Speech Therapist costs on *Schedule B-2* were due to tuition increases and varying speech services needs of the residents. The Provider also stated the increases in Enterals: Medicaid Billable, Consulting and Management Fees - Indirect, Dues-Subscriptions-Licenses, and Repair-Maintenance on *Schedule C* were due to a posting error; the ICF charging for 2010 consulting costs under the six percent contract rate of budgeted revenues; a new membership in an external organization; transitions made to new facilities; and repair services being outsourced.

   We found no adjustments exceeding $500 and 5 percent of non-payroll costs on any schedule.

**Property**

1. ODM requested we compare the Provider's procedures regarding capitalization of fixed assets used for preparing *Schedule D, Capital Cost Center; Schedule D-1, Analysis of Property, Plant and Equipment*; and *Schedule D-2, Capital Additions/Deletions* with the Cost Report instructions and CMS Publication 15-1, and report any variances.

   We compared the Provider's procedures regarding capitalization of fixed assets used for preparing *Schedule D, Schedule D-1* and *Schedule D-2* with the Cost Report Instructions and CMS Publication 15-1.

   We noted one inconsistency between the Provider's capitalization policy and the guidelines in that the Provider does not determine a salvage value when calculating depreciation as required by CMS Publication 15-1, 104.19, which states, "virtually all assets have a salvage value substantial enough to be included in calculating depreciation and only in the rare instance is salvage value so negligible that it may be ignored."

**Recommendation:**

We recommend the Provider calculate a salvage value equal to 10 percent of historical cost when determining the initial net book value to be depreciated for each new capital asset purchase. See procedure 3 for corresponding adjustments.

The Provider's independent accounting firm responded, "We disagree with the assertion that most assets have salvage value, particularly in an ICF/IID setting, in which the capital assets often receive heavy and rough use due to the behavioral characteristics of the residents. We also assert that virtually no providers utilize the salvage value concept in this industry; however, we acknowledge the adjustments are immaterial to this settlement and we are not challenging these findings at this time."

**Property (Continued)**

2. ODM requested that we compare capital assets and corresponding depreciation listed on *Schedule D, Capital Cost Center; Schedule D-1, Analysis of Property, Plant and Equipment;* and *Schedule D-2, Capital Additions/Deletions* to the Provider's Depreciation Schedule and Book Asset Detail report and report differences exceeding $500.
   We compared capital assets and corresponding depreciation listed on *Schedule D, Schedule D-1,* and *Schedule D-2* to the Provider's Depreciation Schedule.

   We found no differences exceeding $500.

3. ODM requested that we select a total of three additions, renovations, and/or deletions reported on *Schedule D-1, Analysis of Property, Plant and Equipment* and *Schedule D-2, Capital Additions/Deletions* and determine if the cost basis, useful life and depreciation expense were in accordance with the Cost Report Instructions and Ohio Admin. Code § 5101:3-3-01 (BB), and report any differences.

   We selected two additions and one deletion reported on *Schedule D-1* and reviewed the cost basis, useful life and depreciation expense to determine whether they were in accordance with the Cost Report Instructions and 5101:3-3-01 (BB). We also reviewed the assets used in residential care to determine if they should be reclassified as the Costs of Ownership in accordance with Ohio Admin § 5101:3 and CMS Publication 15-1.

   We found differences related to depreciating assets without a salvage value (see also procedure 1 above) as reported in Appendix A.

4. ODM requested we review the rent and lease agreements to determine if any related party lease costs were recorded in accordance Ohio Admin. Code §§ 5101:3-3-01(BB) and 5101:3-3-84.3, and that non-related party leases meet the requirements of FASB 13, if costs were recorded in *Schedule D, Analysis of Property, Plant and Equipment* in Lease and Rent Accounts 8060 or 8065, and report any differences.

   We reviewed rent and lease agreements and found no differences.

5. ODM requested we compare the renovation costs and financing costs in the Non-extensive Renovation Letter to *Schedule D-1, Analysis of Property, Plant and Equipment,* if costs were recorded in *Schedule E, Balance Sheet*, Account 1300, Renovations, and report any differences.

   We did not perform this procedure because there were no costs recorded in *Schedule E, Balance Sheet,* Account 1300, Renovations.

6. ODM requested we review the Fixed Asset/Depreciation Listing to ensure transportation expenses were reasonable, allowable and related to patient care as defined in CMS Publication 15-1. ODM also requested we review the W-2s to determine if any corporate officers and owners who exclusively used vehicles reported additional compensation or were adjusted from allowable expenses pursuant to CMS Publication 15-1, Chapter 9 if transportation costs are recorded in *Schedule D-1, Analysis of Property, Plant and Equipment* and report any differences.

   We did not perform this procedure because there was no transportation cost recorded in *Schedule D-1* for transportation.

**Payroll**

1. ODM requested that we compare the Provider's payroll expenses to the amounts reported on *Schedule B-1, Other Protected Costs*; *Schedule B-2, Direct Care Cost Center*; *Schedule C, Indirect Cost Care Center*; *Schedule C-1, Administrator's Compensation* and *Schedule C-2, Owner's Relatives Compensation* and report reclassifications between schedules and adjustments resulting in decreased costs or hours exceeding five percent on any schedule.

   We compared all salary, fringe benefits and payroll tax entries and hours worked reported on *Schedule B-1, Schedule B-2, Schedule C, Schedule C-1,* and *Schedule C-2* to the Provider's General Ledger Account Analysis and General Ledger Trial Balance reports to identify variances exceeding five percent of total payroll costs or hours reported on any schedule.

   We found no differences exceeding five percent on any schedule.

2. ODM requested that we select a sample of 10 employees reported on *Schedule B-1, Other Protected Costs*; *Schedule B-2, Direct Care Cost Center*; *Schedule C, Indirect Cost Care Center*; and *Exhibit 3, Home Office Trial Balance* and determine if any salaries and fringe benefits expenses exceeding $500 were not properly allocated and classified or were unallowable.

   We selected 10 employees (including all Administrators and Owners) and compared the Provider's job description to the schedule in which each employee's salary and fringe benefit expenses were reported to determine if the payroll costs were allowable under CMS Publication 15-1, were properly classified, allocated and allowable in accordance with Ohio Admin. Code § 5101:3, CMS Publication 15-1, Chapter 9 and Section 2150, and the Cost Report Instructions.

   We found no differences.

3. ODM requested that we compare the 2011 payroll costs reported on *Schedule B-1, Other Protected Costs; Schedule B-2, Direct Care Cost Center; Schedule C, Indirect Cost Care Center; Schedule C-1, Administrator's Compensation;* and *Schedule C-2, Owner's Relatives Compensation* by chart of account code to payroll costs reported by chart of account code in 2010 and obtain the Provider's explanation for five payroll variances that increased by more than five percent from the prior year's schedules. ODM also asked us to report adjustments exceeding $500 and five percent of payroll costs on any schedule.

   We compared the 2011 payroll costs reported on *Schedule B-1, Schedule B-2, Schedule C, Schedule C-1,* and *Schedule C-2* by chart of account code to payroll costs reported by chart of account code in 2010 and found three payroll variances that increased by more than five percent and $500 from the prior year's schedules.

   The Provider's stated the increase in Program Director and Worker's compensation and Employee Fringe Benefit costs on *Schedule B-2* was due to adding the Program Director position in 2011 and increases in employee health insurance claims.

   We found no variances exceeding $500 and five percent of payroll costs on any schedule.

**Revenue**

1. ODM requested us to compare all revenues on the Provider's Revenue Ledger with those revenues reported on *Attachment 1, Revenue Trial Balance* and report differences exceeding five percent of total revenues reported.

   We compared all revenues on the Provider's Income Statement and Trial Balance report with those revenues reported on *Attachment 1* to determine if all revenues were reported in accordance with Ohio Admin. Code § 5101:3, CMS Publication 15-1, and the Cost Report Instructions.

   We found no differences exceeding five percent.

2. ODM requested we scan the Provider's Revenue Ledger to identify any revenue offsets/applicable credits exceeding $500 which the Provider did not record on *Attachment 2, Adjustments to Trial Balance* or were not offset against expenses on *Schedule B-1, Other Protected Costs*; *Schedule B-2, Direct Care Cost Center*; or *Schedule C, Indirect Cost Care Center*.

   We scanned the Provider's Income Statement and Trial Balance reports for revenues which roll up to *Attachment 1* and expenses on *Schedule B-1, Schedule B-2,* and *Schedule C* to identify any revenue offsets or applicable credits which were not reported on *Attachment 2* or *Schedule B-1*, *Schedule B-2* or *Schedule C* to offset corresponding expenses in accordance with CMS Publication 15-1, Chapters 1, 6 and 8.

   We did not identify any unrecorded revenue offsets or applicable credits exceeding $500.

**Assets, Liabilities, and Owner's Equity**

ODM requested us to perform procedures 1 through 6 below if the Provider was a for-profit provider and if *Schedule E-1, Return on Equity Capital of Proprietary Providers* reported equity above zero.

1. ODM requested we compare Assets and Liabilities on the *Schedule E, Balance Sheet* with the Provider's trial balance report and other supporting documentation for those accounts greater than five percent of total reported assets or liabilities and identify any unsupported, unallowable or improperly classified amount per Ohio Admin. Code § 5101:3, CMS Publication 15-1, or the Cost Report Instructions.

   We compared Assets and Liabilities on the *Schedule E* with the Provider's Trial Balance and General Ledger Trial Balance reports for those accounts greater than five percent of total reported assets or liabilities. We also noted if any amount was unsupported, unallowable or improperly classified per Ohio Admin. Code § 5101:3, CMS Publication 15-1, or the Cost Report Instructions.

   We found differences as reported in Appendix A, see also procedure 3 below.

2. ODM requested we determine if the Provider is on a proper accrual basis and if their accrual policies are applied consistently between periods as required by the Cost Report Instructions and report any differences.

   We determined the Provider is on a proper accrual basis and we found no inconsistencies between periods.

**Assets, Liabilities, and Owner's Equity (Continued)**

3. ODM requested we compare the Provider's ending account balance with the beginning balance for all accounts on *Schedule E, Balance Sheet* and obtain an explanation for any account ending balance with variances exceeding 25 percent of the beginning balance or $100,000 and report any adjustments.

   We compared the Provider's ending account balance with the beginning balance for all accounts on *Schedule E* and obtained an explanation for any account ending balance with variances exceeding 25 percent of the beginning balance or $100,000.

   The Provider stated the increases in Petty Cash, Prepaid Expenses, Property Plant and Equipment, and Accumulated Depreciation were related to the sale and closing of old facilities and moving into new facilities. The increase in Cash in Bank - General Account and Accounts Receivable was due to normal fluctuations in patient funds and slow payments from the new MITS system due to reconciliation issues. The Provider also stated the increase in Other Receivable was because the negative beginning balance was incorrectly categorized as an asset in the prior year when it was actually a liability to the parent company.

   The variances above did not result in adjustments in Appendix A; however, the Provider also stated that Cost Settlement, Deferred Charges and Other Assets, and Accrued Compensation variances were due to negative accounts that were incorrectly categorized as either assets or liabilities related to the parent company or costs owed to the State.

   We reported differences in Appendix A, see also procedure 1 above.

4. ODM requested we compare the savings account balance on the trial balance report to *Schedule E, Balance Sheet* to determine if total cash on hand from investments/savings exceeds three months of the Provider's total annual operating expenses as reported *Schedule A-3, Summary of Costs* and is not allowable equity as Invested Funds, pursuant to CMS Pub. 15-1, Section 1218.2, and report any differences.

   We did not perform this procedure because no savings account balances were reported on the Trial Balance report or *Schedule E*.

5. ODM requested we compare reconciling items on the bank reconciliation report/schedule with the December 2011 bank statement and trial balance report, and report any differences.

   We did not perform this test because the Provider had a zero balance account and did not prepare a bank reconciliation report. However, we compared the December 2011 bank statement balance with and Trial Balance report.

   We found no variances.

6. We compared amounts reported on *Schedule E-1, Return on Equity Capital of Proprietary Providers* to supporting documentation to ensure net equity calculations for Capital, Due from Owners/Officers, Related Party Loans, Equity in Assets Leased from Related Parties, or Home Office Equity were in accordance with CMS Publication 15-1 and Ohio Admin. Code § 5101:3-3-01(BB).

   We found no differences.

We received a response from Provider's independent accounting firm to exceptions noted above under Property, procedure 1 and Non-Payroll Expenses, procedure 3. We did not audit the response related to Property, procedure 1 and, accordingly, we express no opinion on it. However, we responded under Non-Payroll Expenses, procedure 3 in the section Auditor of State's Conclusion.

We were not engaged to and did not conduct an audit, the objective of which would be the expression of an opinion on the Provider's Cost Report. Accordingly, we do not express such an opinion. Had we performed additional procedures, other matters might have come to our attention that would have been reported to you.

This report is intended solely for the use of the managements of the Provider, the Ohio Department of Medicaid, the Ohio Department of Developmental Disabilities, and the Centers for Medicare and Medicaid Services, and is not intended to be, and should not be used by anyone other than these specified parties.

**Dave Yost**
Auditor of State

January 28, 2015

**Appendix A**
**Takoda**
**2010 Income and Expenditure Report Adjustments**

| | Reported Amount | Correction | Corrected Amount | Explanation of Correction |
|---|---|---|---|---|
| **Schedule A-1 Summary of Inpatient Days** | | | | |
| 12. 12. December - Authorized Days (1) | 1,674 | (9) | $ 1,665 | To reclassify hospice days |
| 12. 12. December - Veterans and Other Days (8) | - | 9 | $ 9 | To reclassify hospice days |
| **Schedule B-2 Direct Care Cost Center** | | | | |
| 21. 21. Consulting and Management Fees-Direct Care - 6210 - Other/Contract Wages (2) | $ 110,420 | $ (60,972) | $ 49,448 | To reclassify unallowable portion of Management fees |
| **Schedule C Indirect Care Cost Center** | | | | |
| 28. 28. Consulting and Management Fees - Indirect - 7215 - Other/Contract Wages (2) | $ 283,443 | $ (182,916) | $ 100,527 | To reclassify unallowable portion of Management fees |
| 40. 40. Dues, Subscriptions and Licenses - 7270 - Other/Contract Wages (2) | $ 19,323 | $ (159) | $ 19,164 | To reclassify heating repair costs |
| 44. 44. Help Wanted/Informational Advertising - 7290 - Other/Contract Wages (2) | $ 4,695 | $ (363) | $ 4,332 | To reclassify cost of flowers for residents |
| 47. 47. Other Indirect Care - 7305 - Other/Contract Wages (2) | $ - | $ 363 | $ 363 | To reclassify cost of flowers for residents |
| 52 52. Repair and Maintenance - 7340 - Other/Contract Wages (2) | $ 179,897 | $ (1,289) | | To reclassify furniture costs |
| | | $ 159 | $ 178,767 | To reclassify heating repair costs |
| 53. 53. Minor Equipment - 7350 - Other/Contract Wages (2) | $ - | $ 1,289 | $ 1,289 | To reclassify furniture costs |
| 68. 68. Other Non-Reimbursable - Specify Below - 9725 - Other/Contract Wages (2) | $ 740 | $ 60,972 | | To reclassify unallowable portion of Management fees |
| | | $ 182,916 | $ 244,628 | To reclassify unallowable portion of Management fees |
| **Schedule D-1 Analysis of Property, Plant and** | | | | |
| 5. 5. Equipment - Depreciation this Period (7) | $ 249,233 | $ (170) | $ 249,063 | To remove salvage value from 2011 purchases |
| **Schedule E - Balance Sheet** | | | | |
| 8. 8. Cost Settlement - End of Period | $ (137,466) | $ 137,466 | $ - | To reclassify negative asset to liability owed to the State |
| 22. 22. Deferred Charges and Other Assets - End of Period | $ (4,638,345) | $ 4,638,345 | | To reclassify negative deferred charge to parent company liability |
| | | $ 319,666 | $ 319,666 | To reclassify negative liability to deferred charge of parent company |
| 27. 27. Cost Settlements - End of Period | $ - | $ 137,466 | $ 137,466 | To reclassify negative asset to liability owed to the State |
| 30. 30. Accrued Compensation - End of Period | $ (319,666) | $ 319,666 | | To reclassify negative liability to deferred charge of parent company |
| 33. 33. Other Liabilities | | $ 4,638,345 | $ 4,638,345 | To reclassify negative deferred charge to parent company liability |

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# Dave Yost • Auditor of State

**PROVIDER SERVICES, INC. – TAKODA TRAILS**

**BUTLER COUNTY**

**CLERK'S CERTIFICATION**

**This is a true and correct copy of the report which is required to be filed in the Office of the Auditor of State pursuant to Section 117.26, Revised Code, and which is filed in Columbus, Ohio.**

Susan Babbitt

**CLERK OF THE BUREAU**

**CERTIFIED**
**FEBRUARY 10, 2015**

88 East Broad Street, Fourth Floor, Columbus, Ohio 43215-3506
Phone: 614-466-4514 or 800-282-0370 Fax: 614-466-4490
**www.ohioauditor.gov**