Department of Health and Human Services
DEPARTMENTAL APPEALS BOARD
Appellate Division

Gilman Care Center
Docket No. A-11-10
Decision No. 2357
December 30, 2010

FINAL DECISION ON REVIEW OF ADMINISTRATIVE LAW JUDGE DECISION

By letter dated October 4, 2010, Gilman Care Center (Gilman) appealed the September 20, 2010 decision of Administrative Law Judge (ALJ) Carolyn Cozad Hughes upholding the determination of the Centers for Medicare & Medicaid Services (CMS) that Gilman was not in substantial compliance with Medicare requirements. *Gilman Care Center*, DAB CR2247 (2010) (ALJ Decision). The ALJ affirmed the imposing of a civil money penalty (CMP) of $6,800 per day for one day of immediate jeopardy and a CMP of $400 per day for 35 days of noncompliance that did not constitute immediate jeopardy. On appeal, Gilman challenges only the amount of the CMPs and solely on the grounds that Gilman's current financial condition means that it is unable to pay. We reject Gilman's arguments because they were not raised below and because the supporting evidence now proffered, even if we admitted it, does not demonstrate that Gilman cannot pay the CMP.

For the reasons explained below, we uphold the ALJ Decision and affirm the total CMP amount of $20,800.

Background and ALJ Decision

The facts set out in the ALJ Decision are no longer in dispute and are summarized here to give the reader context. The Wisconsin Department of Health Services conducted a survey of Gilman in April 2009 and found that the facility was not in substantial compliance with four Medicare participation requirements. The most severe noncompliance constituted a failure to provide an environment as free from accident hazards as possible and to ensure adequate supervision and assistance devices to prevent foreseeable accidents. ALJ Decision at 4. The result was that multiple elderly residents suffered repeated falls, many involving serious injuries, including one woman who fractured both hips and her femur. *Id*. at 4-23, 27. (The ALJ carefully detailed numerous incidents involving individuals known as R5, R12, R7, R2, R15, and R10. *Id.* at 4-23.) Despite these recurrent episodes, the facility did not adequately assess and plan for the residents' changing needs and did not implement the interventions that were called for by

its own care plans to protect its residents from the foreseeable risks of a multitude of falls over the course of the fall and winter of 2008-2009. *Id.* at 1.

Having found that Gilman was not in substantial compliance, the ALJ considered and discussed the relevant factors set out in the regulation in evaluating the reasonableness of the amount of the CMPs imposed. ALJ Decision at 28-29. She found that Gilman had been noncompliant with multiple regulatory requirements at three prior surveys in December 2006, January 2008 and October 2008, including twice under the same provisions under which immediate jeopardy was found at the April 2009 survey. *Id.* at 28. The ALJ concluded that "[b]ased on this history, CMS could reasonably justify a very substantial CMP as necessary to produce corrective action." *Id.* at 28-29. She set out her assessment of the nature and relationship among the deficiencies, and the facility's culpability in regard to them, with particular reference to two of the most vulnerable residents as follows:

> With respect to the remaining deficiencies, particularly those that presented immediate jeopardy, I find that the sheer number of vulnerable and unprotected residents suffering injuries justifies a substantial penalty. Further, I find that staff were particularly culpable in their treatment of R5 and R12. Without regard to her care plan's instructions (she was supposed to have a one to two-person assist with a gait belt), staff knowingly allowed R5 to walk unassisted and to stand up from her chair without intervening. After she fell, no one seems even to have recognized that they had ignored the fall prevention instructions in her care plan. Staff also knew that R12 was particularly vulnerable to falls when she was exhausted and agitated. Yet, rather than intervening when they witnessed her engaging in risky behavior, they sent her away. I recognize that staff may not have been able to supervise as needed because the facility was insufficiently staffed. If so, the facility's management is culpable.
>
> I therefore find that the facility's history, the number, scope and severity of the deficiencies cited, and the staff's culpability, justify the penalties imposed.

Id. at 29. The ALJ noted that, although Gilman "complains that the penalty imposed has greater financial impact on it than it would others because the facility is small," Gilman "does not claim that its financial condition prevents it from paying the CMP." *Id.* Gilman disputes before us only the last comment. Notice of Appeal (NA) at 1.

<u>Arguments of the Parties</u>

Gilman's owner states that he seeks to appeal the CMP amount "not because I believe it was egregious, but because this facility is unable to pay this amount due to continued low census and other financial factors." NA at 1. Gilman states that "[r]evenues have never been adequate to meet even basic facility operations," that the owners "have not received

a nickel in facility profits since acquiring the facility in October, 2007 and have actually put in hundreds of thousands of dollars to keep the entity operating and in efforts to improve the quality of care, and that imposition of the $20,800 forfeiture could well result in a default operation and closure of the current facility." *Id.* at 1-2. Along with its appeal, Gilman submitted the following documents that were not presented to the ALJ:

- A bank forbearance agreement dated June 28, 2010
- An August 31, 2010 balance sheet
- Income statements from January 2010 through August 2010
- Cash flow projections from June 2010 through September 2010 (estimated)
- Disclosure of expenses due to related entities
- Schedule of amounts due to related companies and/or individuals[1]

CMS objects to Gilman's arguments about its ability to pay and to the admission of these newly-submitted documents on the grounds that Gilman failed to offer either argument or documentation on this issue before the ALJ and did not explain why it could not have done so. CMS Br. at 6-10. CMS contends that Gilman "waived" its right to submit evidence on its financial condition on appeal and, in any case, failed to show good cause to support its late admission. *Id.* at 8-9. Further, CMS argues that the documents proffered are not relevant to whether the CMPs were reasonable at the time they were imposed in the summer of 2009 and do not, in any case, show that Gilman lacks the resources to pay the CMP. *Id.* at 9-12.

Applicable legal authority

The regulations prescribe the applicable range of CMP amounts as between $50-3,000 per day when immediate jeopardy is absent and between $3,050-10,000 per day when immediate jeopardy is present. 42 C.F.R. §§ 488.408(d), 488.438(a). In determining the reasonableness of the amount of a CMP, the ALJ is to consider the factors set out in 42 C.F.R. § 488.438(f) which are (1) the facility's history of noncompliance, (2) its financial condition, (3) factors specified in section 488.404, and (4) the facility's degree of culpability, defined as including neglect, indifference, or disregard for resident care, comfort or safety. Absence of culpability is not a mitigating factor. 42 C.F.R. § 488.438(f)(4). The factors specified in section 488.404, in turn, include the scope and severity of the deficiencies, their relation to each other, and the facility's prior history of noncompliance in general and with the particular deficiencies at issue.

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[1] Gilman submitted additional documents with its reply brief consisting of a 2009 monthly income statement, vender ledger printouts showing payments to the lawyer who represented Gilman before the ALJ, invoices from that lawyer, and a September 2010 balance sheet.

Standard of review

The Board's standard of review on a disputed conclusion of law is whether the ALJ decision is erroneous. The Board's standard of review on a disputed finding of fact is whether the ALJ decision is supported by substantial evidence on the record as a whole. *Guidelines – Appellate Review of Decisions of Administrative Law Judges Affecting a Provider's Participation in the Medicare and Medicaid Programs*, http://www.hhs.gov/dab/divisions/appellate/guidelines/prov.html; *Batavia Nursing and Convalescent Inn*, DAB No. 1911, at 7 (2004), *aff'd, Batavia Nursing & Convalescent Ctr. v. Thompson*, 143 F. App'x 664 (6th Cir. 2005).

Analysis

1. Admission of new evidence on appeal lies in the sound discretion of the Board.

The regulations governing this appeal provide that the Board "may admit evidence into the record in addition to the evidence introduced at the ALJ hearing (or the documents considered by the ALJ if the hearing was waived) if the Board considers that the additional evidence is relevant and material to an issue before it." 42 C.F.R. § 498.86(a). Furthermore, section 498.86(b) states that the Board will require production, if it appears that "additional relevant evidence is available." The Board has explained that it will accept additional evidence only if it finds it to be "relevant and material to an issue before it" and will also consider "whether the party that proffers the evidence has demonstrated good cause for not producing the evidence during proceedings before the ALJ." Guidelines -- Appellate Review of Decisions of Administrative Law Judges Affecting a Provider's Participation in the Medicare and Medicaid Programs (Dec. 1, 2008), available at http://www.hhs.gov/dab/divisions/appellate/guidelines/prov.html.

Under the regulations, a party that failed to present evidence to the ALJ is not entitled as of right to have that evidence admitted on appeal to the Board, and the Board is not obligated to accept the new evidence. On the other hand, the same regulations empower the Board to admit new evidence when it is relevant and material to the sound resolution of an issue presented by the appeal. We therefore reject CMS's suggestion that Gilman's failure to offer these documents to the ALJ amounts to a waiver barring Gilman from proffering them before us.

CMS cites three prior Board cases in support of its waiver claim, none of which are on point. CMS Br. at 9, citing *Columbus Park Nursing & Rehab. Ctr.,* DAB No. 2316, at 11-12 (2010); *Foxwood Springs Living Ctr.*, DAB No. 2294, at 13-14 (2009); and *Palm*

Garden of Gainesville, DAB No. 1922, at 6 n.3 (2004). First, all three cases involve parties raising new arguments on appeal rather than proffering additional evidence.[2]

Second, the cases do not stand for the proposition that the Board is precluded from considering arguments that were not presented to the ALJ but rather that the Board is not required to reach such arguments. In *Columbus Park* and *Foxwood*, moreover, although the Board noted that it need not reach the new arguments, it found that they were, in any event, without merit. DAB No. 2316, at 11-12; DAB No. 2294, at 13-14.

For similar reasons, we conclude that Gilman is not required under the regulations to prove that good cause prevented it from presenting the additional evidence to the ALJ. We do however, as our guidelines indicate, consider a party's reasons for the late proffer of evidence in deciding whether to exercise our discretion to admit the evidence.

Gilman basically offers two explanations for its failure before the ALJ to clearly assert inability to pay or to proffer the documents which it now points to as evidence of its financial condition. Gilman argues first that, until the ALJ issued her decision upholding the CMP, its focus and that of the counsel whom it engaged was on disproving the deficiency allegations and improving conditions in the facility. Gilman Reply Br. at 2, 7. This explanation merely amounts to a strategic litigation choice.

Gilman next contends that it was not fully aware of the seriousness of its financial condition until late in the proceedings. *Id.* at 3-8. This explanation, by contrast, is more complicated and fact-based, portraying both the facility's financial state and the management's access to information about it as moving targets. Thus, Gilman asserts that the owners learned only after replacing the facility's bookkeeper that its accounts receivables were "largely overstated" so that an expected "reservoir of funding" dried up. *Id.* at 8. Furthermore, Gilman states, between the end of the ALJ hearing, the issuance of the ALJ Decision, and its appeal to the Board, Gilman underwent a number of problems that evidenced a worsening financial condition, including obtaining a forbearance agreement with its bank and a recoupment of $41,500 by the state Medicaid program. *Id.* To resolve when Gilman's management was or should have been aware of specific financial facts would involve us in reviewing the same documents and contentions that we would need to address Gilman's argument on appeal that it cannot pay the CMP.

CMS also argues that admitting these documents on appeal effectively allows Gilman "to make uncontested claims in which it has substantial self-interest" because "CMS and the ALJ had no chance to examine the documents for accuracy." CMS Br. at 9-10. This

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[2] CMS does also argue that Gilman should be barred from making arguments about its ability to pay because its only contention before the ALJ about the amount of the CMP was that the impact was greater on a facility as small as Gilman. CMS Br. at 7-8, 10. We agree that Gilman's briefing below made only oblique reference to the financial impact of the CMP amount, but we do not agree that Gilman's failure to expand on this argument below would preclude us from considering the facility's financial condition if we found the evidence compellingly established the facility was unable to pay. As explained below, the additional evidence proffered by Gilman does not amount to such proof.

argument is without merit. By definition, any additional evidence offered on appeal will not have been examined by the ALJ, yet section 498.86(a) expressly provides for admission of such evidence when relevant and material. CMS, however, has had an opportunity to examine the documents and identify any concerns as to accuracy, authenticity or relevance during these proceedings, did so in its brief, and did not request any additional time for its examination. The evidence proffered is not testimonial in nature so we see no need to remand to the ALJ to make an initial determination of credibility. Admitting the evidence does not mean accepting as uncontested any claims made by Gilman about what the documents prove, contrary to CMS's assertions. We discuss in the next section our evaluation of the proffered evidence.

We therefore determine to exercise our discretion to admit the additional evidence proffered and proceed to consider whether that evidence proves that the CMP amounts should be reduced based on Gilman's financial condition.

2. Gilman has not demonstrated that the CMP amounts imposed are unreasonable.

Before discussing whether the new evidence relating to Gilman's financial condition alters the conclusion reached by the ALJ that the CMP amounts are reasonable, we first note several constraints on any reduction of those amounts. Having upheld CMS's determination that Gilman was not in substantial compliance during 36 days and that its noncompliance rose to the level of immediate jeopardy during one of those days, the ALJ was precluded by regulation from reducing the per-day CMPs below $50 for noncompliance less than immediate jeopardy and $3,050 for immediate jeopardy. 42 C.F.R. § 488.438(a),(e); *see also* 59 Fed. Reg. 56,116, at 56,206 (Nov. 10, 1994) (when ALJ "finds noncompliance supporting the imposition of [a CMP], he or she must remedy it with some amount of penalty consistent with the ranges of penalty"). As a practical matter, therefore, the total CMP amount cannot be less than $3,050 plus $1,750 ($50 times 35) or $4,800.

Financial condition, moreover, is only one of the factors that must be considered in evaluating the reasonableness of the amount of a CMP. Here, the ALJ expressly considered the other factors. ALJ Decision at 28-29. She concluded that a "substantial penalty" was appropriate in light of Gilman's history of noncompliance, the "sheer number of vulnerable and unprotected residents suffering injuries," and the facility's culpability.[3] *Id*. Gilman did not appeal these conclusion and indeed recognized that the amount imposed is not "egregious" under the circumstances. Even if we were convinced (which we are not) that the facility's financial condition justified some reduction of the $20,800 total, we would have to take into account these undisputed factors cutting the other way.

[3] The ALJ's assessment that a substantial CMP would be necessary to motivate corrections appears supported by later events to which Gilman refers. Although Gilman claims that the facility has been making improvements in quality, it also acknowledges being cited again for immediate jeopardy in June 2010, as well as for noncompliance in an annual survey in July 2010. Gilman Reply Br. at 8-9.

Turning to the evidence offered as to Gilman's financial condition, we note that the Board has long held, as CMS recognizes in its brief, that the correct inquiry in considering financial condition is "whether the facility has adequate assets to pay the CMP without having to go out of business or compromise resident health and safety." CMS Br. at 10, quoting *Sanctuary at Whispering Meadows*, DAB No. 1925, at (2005); *see also Embassy Health Care Ctr*., DAB No. 2327, at 12 (2010); *Milipitas Care Center*, DAB No. 1864 (2003). This inquiry reflects the following explanation set out in the preamble to the regulation adopting the factors to be considered in setting the amount of a CMP:

> [I]t is a statutory requirement that a facility's financial condition be considered as a factor to determine the amount of the civil money penalty. We do not specify in the regulation what we will examine in determining the facility's financial condition, because these factors are unique for each facility. Therefore, it is the responsibility of the facility to furnish the information it believes appropriately represents its financial status. We consider a facility's financial condition in conjunction with the other factors specified in the rule when determining the amount of a civil money penalty, because **it is not our intent to put facilities out of business**, and the amount of the civil money penalty is determined on a case by case basis.

59 Fed. Reg. at 56,204 (emphasis added); *see also Windsor Health Care Center*, DAB No. 1902 (2003) ("The key factor in assessing financial condition is whether the facility has adequate assets to pay the CMP without having to go out of business or compromise resident health and safety"). We therefore accord little weight to Gilman's claims that its "revenues have never been adequate to meet even basic facility operations" or that its owners "have not received a nickel in facility profits since acquiring the facility in October, 2007." NA at 1. We focus instead on whether Gilman has demonstrated that "imposition of the $20,800 forfeiture could well result in a default operation and closure of the current facility," as Gilman alleged, or that it would compromise resident health and safety. *Id*. at 2. We conclude that it has not.

In weighing Gilman's evidence, we note that Gilman bears the burden of proving its financial condition by the preponderance of the evidence. *Western Care Mgt. Corp. d/b/a Rehab. Specialties,* DAB No. 1921, at 91 (2004) ("The burden in this proceeding is not on CMS to prove Rehab's ability to pay the CMP but on Rehab to present evidence that the CMP would render it insolvent or adversely affect its ability to provide its residents with quality care."). The primary evidence Gilman proffered to show the limited resources from which to pay the CMP is in the form of unaudited balance sheets from August and September 2010 showing approximately $2 million in total assets. Gilman admits that these documents are unaudited (and therefore not independently verified), but asserts that management submitted these figures to the State Medicaid agency under "threat of criminal

sanction." Gilman Reply Br. at 6. The record before us contains no proof that the same figures were submitted to, much less accepted or verified by, any state or federal agency, and the documents are not accompanied by any sworn statement as to their accuracy. The absence of any verification is particular troubling in light of Gilman's own description of "marginal administrative competencies and, most of all, bookkeeping deficiencies" at the facility, including replacement of four bookkeepers in two years, as well as a substantial Medicaid overpayment. *Id.* at 8.

CMS points out that the total CMP amounts to less than one per cent of the assets shown on the balance sheets. CMS Br. at 10. Gilman acknowledges that fact but argues that "most of the assets are illiquid" and that "the total capital is a negative" amount of over $200,000. Gilman Reply Br. at 7. Even assuming that significant assets, such as buildings and land, are illiquid, we are not persuaded that sufficient assets could not be liquidated to pay a CMP of $20,800 where the September 2010 balance sheet shows unidentified "other assets" alone of $65,007.

As for the negative capital balance, we note that the liabilities listed include owners' contributions of almost $300,000 as well as a $97,000 advance from owner. Gilman also provided a document entitled "schedule of amounts due to related companies/individuals" which lists $167,000 owed to three co-owners, a "non compete" obligation of about $188,000 to an individual named Wayne Zastrow, a debt of over $86,000 to Fall Creek Valley Care Center, and $148,000 in two operating lines of credit to M&I Bank.[4] Gilman's only explanation is that "[n]o moneys have been taken or received from any ownership member or other facility from Gilman other than a few (about three in three years) as short term loans TO Gilman." Gilman Reply Br. at 7 (emphasis in original). These remarks miss the point that the facility may be expected to satisfy its obligations to the federal government before making payments to its owners. Even on the face of the balance sheet provided by Gilman, eliminating the liabilities to owners from the balance sheet would appear to mean a sufficient positive capital balance to more than cover the CMPs without shutting the facility or compromising resident care.

The remaining documentation largely addresses Gilman's cash flow and profitability, and is therefore of even more limited value. As the Board has explained repeatedly, a facility's "annual profits or losses may not be an accurate reflection of a facility's financial health or ability to pay, and must be considered in the light of such other indicators as the facility's financial reserves, assets, credit-worthiness, and 'other long-

[4] Gilman does not explain its relationship to this bank, but suggests that we should consider the bank's entry into a forbearance agreement with Gilman on June 28, 2010 as a generally "accepted harbinger of serious financial problems." Gilman Reply Br. at 6. The question before us is not whether Gilman has serious financial problems but whether it is unable to pay a $20,800 CMP without closing or providing inadequate care to its residents. Whatever we might otherwise infer from the bank entering into a forbearance agreement, we can make no inference favorable to Gilman based on such an agreement with a related party without more information.

term indicia of its survivability.'" *Guardian Care Nursing & Rehab. Ctr.*, DAB No. 2260, at 8 (2009), citing *Kenton Healthcare, LLC,* DAB No. 2186 (2008) (all indicia of financial situation, as well as financing options, not merely cash flow, considered for this factor) and *Windsor Health Care*, DAB No. 1902 (2003) (adequacy of assets, not profits, the relevant inquiry). Gilman provided with its notice of appeal an income statement for the eight months ending August 21, 2010 showing specific expenses. It later submitted with its reply brief income statements with monthly totals for calendar years 2009 and 2010 through September.[5] The monthly income shown on the 2009 statement fluctuates between a loss of $7,442 in August and a loss of $216,538 for December, but calculated after subtracting over $11,000 attributed to depreciation and amortized non-compete agreement costs. The 2010 monthly income is shown as ranging from a loss of $46,566 in March and a gain of $32,804 in August, again after subtracting these "paper" expenses that do not involve actual cash outlays. Gilman also provided some documents to illustrate its varying census of residents, which Gilman acknowledged was showing "promising" increases in recent months. Gilman Reply Br. at 6. Far from making a persuasive case that its financial condition would make payment of the CMPs impossible, these records raise more issues than they resolve. For example, it appears that two months of paper expenses would suffice to cover the total CMP amount. The facility has been able to sustain operating losses of up to ten times the CMP amount without closing, making it less credible that paying the CMP would put it out of business. The trajectory shown over 2010 appears to be one of financial improvement. In short, the documentation offered is inconclusive and insufficient to prove inability to pay.

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[5] CMS contended that the relevant time frame was the summer of 2009 when Gilman "accrued the CMP." CMS Br. at 9. CMS cites no authority for the proposition that, in weighing financial condition as a factor in evaluating the reasonableness of the amount of a CMP on appeal, the assessment should address whether the facility would have been able to pay it as of the time it was imposed. (Actually, the CMP here was imposed for the period from April 23, 2009 through May 28, 2009, so it is not entirely clear what CMS means by its reference to the summer of 2009.) This retrospective assessment would appear to be inconsistent with the requirement that the ALJ *perform a de novo evaluation of the relevant factors rather than review CMS's evaluation of them. Cal Turner Extended Care Pavilion*, DAB No. 2030 (2006), quoting *CarePlex of Silver Spring*, DAB No. 1683, at 17-18 (1999) ("The ALJ does not conduct "a quasi-appellate review of the regularity of [CMS's] determination" but rather makes a de novo determination of the reasonableness of the amount of the CMP selected by CMS "based on evidence in the record as a whole as developed before the ALJ."). Furthermore, given that one purpose which CMS has identified for considering financial condition is to avoid driving a facility out of business, the more relevant time would seem to be when the facility would have to pay the CMP once administrative action is final, which may, as here, be more than a year later. We need not finally resolve this question, however, because we conclude that Gilman's documentation does not establish that it would be unable to pay the CMP amount imposed whichever time frame is considered.

Conclusion

For the reasons explained above, we uphold the ALJ Decision in its entirety.

/s/
Judith A. Ballard

/s/
Constance B. Tobias

/s/
Leslie A. Sussan
Presiding Board Member