COMMONWEALTH of VIRGINIA

Department of Medical Assistance Services

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December 1, 2014

MEMORANDUM

TO: The Honorable Walter A. Stosch
Co-Chairman, Senate Finance Committee

The Honorable Charles J. Colgan
Co-Chairman, Senate Finance Committee

The Honorable S. Chris Jones
Chairman, House Appropriations Committee

FROM: Cynthia B. Jones Cynthia B. Jones

SUBJECT: Report on Audits of Home-and Community-Based Services

The 2015-16 Appropriation Act, Item 301 PPP, states:

> *The Department of Medical Assistance Services shall establish a work group of representatives of providers of home- and community-based care services to continue improvements in the audit process and procedures for home- and community-based utilization and review audits. The Department of Medical Assistance Services shall report on any revisions to the methodology for home- and community-based utilization and review audits, including progress made in addressing provider concerns and solutions to improve the process for providers while ensuring program integrity. In addition, the report shall include documentation of the past year's audits, a summary of the number of audits to which retractions were assessed and the total amount, the number of appeals received and the results of appeals. The report shall be provided to the Chairmen of the House Appropriations and Senate Finance Committees by December 1 of each year.*

Should you have any questions or need additional information, please feel free to contact me at (804) 786-8099.

CBJ/

Enclosure

Cc: The Honorable William A. Hazel, Jr., MD, Secretary of Health and Human Resources

Department of Medical Assistance Services
Annual Report to the General Assembly

Report on Audits of Home- and Community-Based Services

December 2014

Report Mandate

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Background

Home and Community-Based Services (HCBS) are provided to individuals enrolled in Medicaid who meet criteria for admission to a nursing facility (NF) or Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) but choose to receive services in a less restrictive and less costly community setting via 1915(c) waiver authority granted by the Centers for Medicare and Medicaid Services (CMS.) The Department of Medical Assistance Services (DMAS) operates six HCBS Waivers including the Technology Assisted, Individual and Family Developmental Disability Support (DD), Elderly or Disabled with Consumer Direction (EDCD), Intellectual Disabilities (ID), Day Support (DS), and Alzheimer's Assisted Living waivers. The ID, DD and DS waivers are operated by the Department of Behavioral Health and Developmental Services (DBHDS). Services may include personal care, respite care, adult day health care, and a range of other support services specific to meeting the needs of seniors and individuals with physical, developmental, and/or intellectual disabilities. Once enrolled in a waiver, a registered nurse, services facilitator or case manager assesses each individual and works with them to create a Plan of Care that outlines the service types and number of hours of care required to assure that their care needs are met while living safely in the community.

Personal care, respite care, and companion care may be provided through an agency or through self-direction (known as consumer-directed or CD). Individuals may select one or both models of service delivery. This report will not address program integrity

activities related to the oversight and reimbursement for CD services. In the CD model, the individual is the employer of the attendant; DMAS contracts with a fiscal employer/agent to process payroll and to perform essential reporting requirements related to wage and withholdings for the assistant. These functions are not analogous to the audits conducted by the Program Integrity Division (PID) and Myers and Stauffer LC (Myers & Stauffer).

DMAS conducts several types of Medicaid integrity activities, including prior authorization of medical necessity, utilization reviews, financial review and verification, investigations of fraud and abuse, as well as quality reviews focused on patient health and safety. Each of these review types correspond to sections of the Code of Federal Regulations (CFR.) Utilization reviews and financial review and verification encompass the audit process which is the major subject of this report.

Utilization Review and Financial Review and Verification (Audits)

Audits are conducted by internal DMAS Program Integrity staff and their contractor, Myers & Stauffer. Audits are conducted to: 1) assure that Medicaid payments are made for covered services that were actually provided and properly billed and documented; 2) calculate and initiate recovery of overpayment; 3) educate providers on appropriate billing procedures; 4) identify potentially fraudulent or abusive billing practices and refer fraudulent and abusive cases to other agencies; and 5) recommend policy changes to prevent waste, fraud and abuse. 42 CFR §456 deals with utilization control and states that "*the Medicaid agency must implement a statewide surveillance and utilization control program that safeguards against unnecessary or inappropriate use of services and against excess payments."*

The Virginia Administrative Code sets forth DMAS policy for the review of personal and respite care and references 42 CFR §§455 and 456 as the authority under which DMAS conducts audits. The provider manual for each provider type states that providers will be required to refund payments made by Medicaid if they fail to maintain any record or adequate documentation to support their claims, or bill for medically unnecessary services. Audits rely on documentation to determine whether the services delivered were appropriate, continue to be needed and are in the amount and kind required. The calculation of overpayments varies, depending on the metric used to determine payment. For claims that are billed based on units of service (i.e., minutes, hours, weeks), if documentation supports a lower number of units than those billed, the overpayment is limited to payments associated with the unsupported units only.

Audit Methodology Workgroup

Pursuant to budget language, DMAS has worked with providers to establish an advisory group of representatives of HCBS providers and held meetings in the summers of 2011, 2012 and 2013. Details on the activities of this workgroup in prior years can be found in DMAS' 2011 report, *Evaluation of Effectiveness and Appropriateness of Review Methodology for Home and Community Based Services,* 2012 *Report of the Activities of*

the DMAS Advisory Group on Audit Methodology for Home- and Community-Based Services and 2013 *Report on Audits of Home- and Community-Based Services.* DMAS convened this workgroup again on July 29, 2014, to provide a forum for providers to discuss the DMAS audit process. As in prior years, this advisory group included representatives from groups representing major providers of HCBS, DMAS Program Integrity and Long Term Care staff, DMAS contract auditor staff, as well as representatives of DBHDS.

Overview of Workgroup Discussion

At the meeting on July 29, 2014, the DMAS PID Director provided an overview of the goals of the workgroup. The DMAS Long-term Care (LTC) Division then provided an update on the status of regulatory changes. The LTC representative stated that regulatory updates for the EDCD waiver program were submitted to the Governor's Office on June 9, 2014. These regulations, however, were completed by the agency on December 6, 2012.

Members of the workgroup expressed concern that these regulations may already be outdated and inadequate. One stakeholder noted that the protracted regulatory process is a challenge to all providers, as it creates uncertainty. Stakeholders also inquired how DMAS audits past claims after regulations have changed. In response, DMAS informed the workgroup that audits are conducted in accordance with the regulations that were in effect when the claim was filed, not at the time the audit is completed.

Following the regulatory update discussion, Myers and Stauffer, LC (MSLC) gave a presentation on the audits they have conducted, including topics such as provider selection, claims review, overview of common errors, and a summary of audit and appeals results. MSLC stated that the main issues of documentation in audits come from issues of the timeliness of reviews and signatures.

Stakeholders inquired as to what DMAS reviews when determining the appropriateness of the provider selection. DMAS reviews the initial provider selection to ensure that they do not overlap with other reviews. In addition, part of the provider selection process involves identifying and removing any repeat reviews.

Stakeholders asked what process is used when there is ambiguity or conflict between the manuals, state code, and federal regulations regarding an error. MSLC responded that they focus their audit findings on areas where there is clear regulatory or policy guidance. If there is ambiguity, MSLC will refer these issues to DMAS subject-matter experts (SME) for clarification. Stakeholders noted that DMAS needs to use caution in identifying the correct SMEs and validating their findings, particularly to ensure the findings are supported by existing regulations.

Stakeholders expressed the opinion that the current documentation requirements used for audits are too punitive, as a single missing signature or form can invalidate an entire period of care. Hospice representatives, in particular, stated that providers are subject to

retractions for an entire quarter if the required quarterly review is not in the medical record, even if monthly reviews are in the record for all months in the quarter. They asserted that in such cases, the monthly reviews should be sufficient. DMAS stated that every program has a supervisory review for a plan of care that is required to be documented and complete. If review is not done for the plan of care, the agency can retract for the entire quarter. DMAS LTC representatives stated that documentation of a chronology of services is a distinct event from performing this supervisory review. In addition, one stakeholder noted issues with obtaining screening documents, as some local Departments of Social Services do not conduct the screening in a timely manner.

One stakeholder inquired about the record storage policies followed by MSLC, specifically how records that are mailed are stored. DMAS noted that MSLC, like all contractors, is HIPAA compliant. MSLC noted that records are kept in a locked room in their office, and the outer office remains locked as well. The room and office are protected by key fob entry. Their retention policy is to keep records for 7 years before destroying. All electronic data is equally protected.

Finally, DMAS conducted a discussion of last year's report, with particular attention given to the information and formatting of the tables included. The group provided several suggestions, which were taken into consideration in the drafting of this report

Summary of the Issues Discussion

Overall, the advisory committee agreed that the tone of the discussions between DMAS and the provider community has significantly improved over the past three years. DMAS will continue to work to address the concerns of providers while maintaining the fiscal integrity of the Medicaid program in Virginia.

Summary of HCBS Audit Activity

In addition to a discussion of the activities of the advisory workgroup, Item 301 PPP directs DMAS to report on the outcomes of prior year audits of HCBS providers, including audit findings and appeals results. The following section presents the results of audits conducted in FY 2012, FY 2013, and FY 2014. Because of the duration of the appeals process, only those audits conducted in FY 2012 and FY 2013 have reached final resolution, and can therefore represent reliable information on appeals outcomes.

Myers & Stauffer Audit Results

Through the end of FY 2013, the Myers & Stauffer (MSLC) audit contract year was in line with the State fiscal year. In FY 2014, DMAS contracted with MSLC for a six-month extension to the contract, and transitioned to a calendar-year contract beginning January 1, 2014. Fewer audits were conducted during this six-month contract extension, and are therefore not comparable on a gross level to prior twelve-month contracts. As a result, this report provides information on audits conducted under the FY 2012 and FY 2013 MSLC audit contracts, as well as the results of the six-month contract extension.

Appeals results for the contract extension are not yet finalized, and as such, are not included in this report.

Myers & Stauffer (MSLC) conducted a total of 297 audits of HCBS providers over two fiscal years: FY 2012 and FY 2013. Audited providers had total billings of more than $124 million during the audited period. MSLC audits examined approximately $38.8 million of billings for HCBS services over this period, representing about 31 percent of audited providers total billings. The following table gives a breakdown of these statistics for each fiscal year, as well as the six-month contract extension.

Table 1: Billings of Providers Audited by Myers and Stauffer, FY 2012-2014

Fiscal Year Audit Conducted	Total Audits Conducted	Total Billings by Audited Providers	Total Billings of Audited Claims	Percent of Total Billings Audited
FY 2012	135	$53,162,515	$15,832,794	30%
FY 2013	162	$70,904,095	$22,927,220	32%
Total (FY 2012-13)	**297**	**$124,066,610**	**$38,760,014**	**31%**
FY 2014 Contract Extension (6 mo.)	79	$21,694,268	$7,807,462	36%

In prior years, stakeholders had expressed some concern that the provider selection process resulted in larger providers being targeted while smaller providers were not being audited. The table below shows the breakdown of Myers & Stauffer (MSLC) audits of HCBS providers by the total dollars in claims filed by selected providers during the audit review period. As is evident from this table, providers of all sizes were audited. While providers with $100,000 to $1 million in claims are still subject to the greatest number of audits, audits of providers with fewer than $100,000 in claims increased substantially from FY 2012 to FY 2013.

Table 2: Number of MSLC Audits by Provider Billing Volume, FY 2012-2014.

Fiscal Year Audit Conducted	Total Audits Conducted	Providers with under $50K in Claims	Providers with $50K to $100K in claims	Providers with $100K to $1M in claims	Providers with over $1M in claims
FY 2012 MSLC	135	40	17	64	14
FY 2013 MSLC	162	42	35	64	21
Total (FY 2012-13)	**297**	**82**	**52**	**128**	**35**
FY 2014 Contract Extension (6 mo.)	79	25	13	36	5

Myers & Stauffer looked at a wide variety of HCBS providers in its audits. The following table shows the number of audits conducted on each HCBS provider type in FY 2012 and 2013, as well as during the six-month FY 2014 contract extension.

Table 3: Provider Types Audited by Myers and Stauffer, FY 2012-2014

Provider Type	FY 2012	FY 2013	Total (FY 2012-FY 2013)	FY 2014 Contract Extension (6 mo.)
ID Waiver	16	33	**49**	2
Personal Care	37	42	**79**	20
Respite Care	26	25	**51**	20
PDN	10	14	**24**	5
Home Health	11	12	**23**	4
Hospice	5	6	**11**	3
Adult Day Healthcare	5	10	**15**	5
Congregate Living (ID)	7	4	**11**	13
Service Facilitator	18	16	**34**	7
Total	**135**	**162**	**297**	**79**

The 297 audits conducted by MSLC in FY 2012 and FY 2013 identified a total of $13,337,564 in improper payments, or about one-third of the total dollars audited. This equates to an average of $44,907 in overpayments identified per audit during this period. It is important to note that the dollar amounts in error in the table are reflective of reductions of $785,472 in FY 2012 and $3,077,627 in FY 2013 due to DMAS' policy of allowing providers to submit additional documentation to correct errors identified at the preliminary review stage before a final overpayment letter is issued. FY 2014 contract extension findings of $1,896,629 reflect a reduction of $1,027,518 from preliminary review to final overpayment due to the same process.

Table 4: Myers and Stauffer Audit Findings, FY 2012-2014

Fiscal Year Audit Conducted	Total Audits Conducted	Total Dollars Audited	Total Dollars in Error	Percent of Audited Dollars in Error
FY 2012	135	$15,832,794	$5,147,445	33%
FY 2013	162	$22,927,220	$8,190,119	36%
Total	**297**	**$38,760,014**	**$13,337,564**	**34%**
FY 2014 Contract Extension (6 mo.)	79	$7,807,462	$1,896,629	24%

While MSLC audits uncovered around $45,000 in overpayments on average in FY 2012 and FY 2013, there was substantial variance from that number in the results of individual audits. Forty-six HCBS audits or about 15 percent of audits conducted, resulted in fewer than $1,000 in overpayments, including 17 audits that found no overpayments. In

addition, only 39 audits resulted in findings of greater than $100,000. The following table gives a breakdown of audit findings by fiscal year.

Table 5: Myers and Stauffer Audits by Amount of Findings, FY 2012-2014

Fiscal Year Audit Conducted	Total Audits Conducted	Total Audits with Findings	Total Audits with findings <$1000	Total Audits with findings $1,000-$10,000	Total Audits with findings $10,000-$100,000	Total Audits with findings >$100,000
FY 2012	135	125	17	36	54	18
FY 2013	162	155	12	47	75	21
Total	**297**	**280**	**29**	**83**	**129**	**39**
FY 2014 Contract Extension (6 mo.)	79	72	12	23	35	2

Of the 280 audits conducted in FY 2012 and FY 2013 in which there were findings, 157 were appealed to the Informal Fact Finding Conference (IFFC) level. Of those 157 appeals, 63 resulted in a reduction of the overpayment findings of the original audit. A substantial proportion of the reductions at IFFC were due to the provider producing additional documentation. In addition, the majority of the reductions in overpayments in FY 2013 were due to billing issues encountered by three CSBs, which resulted in inaccurate information being submitted to the DMAS claims system. These three CSBs represented $1.3 million of the FY 2013 reduction in overpayments.

Table 6: Results of IFFC Appeals of Myers and Stauffer Audits, FY 2012-2013

Fiscal Year Audit Conducted	Total Audits with Findings	Total Audits Appealed	Total Dollars Appealed	Total Reduced at IFFC	Total reduction in overpayments (IFFC)
FY 2012	125	69	$4,042,577	20	$544,986
FY 2013	155	88	$6,551,548	43	$2,279,716
Total	**280**	**157**	**$10,594,125**	**63**	**$2,824,702**

After IFFC, the next level of the appeals process is the formal appeal. Eighteen providers appealed to this level, with a total overpayment amount of $1,605,112 being appealed. Four of those 18 cases resulted in additional reductions to the overpayments identified in the original audit, with a total of $356,064 in overpayments being reduced.

Table 7: Results of Formal Appeals of Myers and Stauffer Audits, FY 2012-2013

Fiscal Year Audit Conducted	Total Formal Decisions	Total Amount Appealed to Formal	Total Reduced at Formal	Total reduction in overpayments (Formal)
FY 2012	13	$1,273,066	3	$265,210
FY 2013	5	$332,046	1	$90,854
Total	**18**	**$1,605,112**	**4**	**$356,064**

DMAS Provider Review Unit (PRU) Audit Results

PRU conducted 43 audits of HCBS providers in FY 2013 and FY 2014. Audited providers had total billings of more than $58.8 million for the audit period. PRU audited claims totaling $7.2 million in HCBS services. The following table gives a breakdown of these statistics for each of the fiscal years.

Table 9: Billings of Providers Audited by PRU, FY 2013-2014

Fiscal Year Audit Conducted	Total Audits Conducted	Total Billings by Audited Providers	Total Billings of Audited Claims	Percent of Total Billings Audited
FY 2013	25	$15,081,155	$3,587,826	24%
FY 2014	18	$43,814,640	$3,652,320	8%
Total	**43**	**$58,895,795**	**$7,240,146**	**12%**

The table below shows the breakdown of (PRU) audits of HCBS providers for FY 2013 and FY 2014 by the total dollars in claims filed by selected providers during the audit review period. As is evident from this table, providers of all sizes were audited by PRU during this time period. It is also worth noting that of the 16 audits of providers with under $50,000 in claims, seven were the result of claims for services rendered after a member had died.

Table 8: Number of Audits by Provider Billing Volume, FY 2013-2014.

Fiscal Year Audit Conducted	Total Audits Conducted	Providers with under $50K in Claims	Providers with $50K to $100K in claims	Providers with $100K to $1M in claims	Providers with over $1M in claims
FY 2013 PRU	25	10	3	9	3
FY 2014 PRU	18	6	5	4	3
Total	**43**	**16**	**8**	**13**	**6**

FY 2013 and FY 2014 PRU audits looked at a variety of HCBS providers with audits of Personal Care providers and Service Facilitators making up more than half of the providers audited. The following table shows the number of audits conducted in FY 2013 and FY 2014 of each HCBS provider type.

Table 10: Provider Types Audited by PRU, FY 2013-2014

Provider Type	FY 2013	FY 2014	Total
ID Waiver	5	4	**9**
Personal Care	9	5	**14**
Respite Care	3	3	**6**
PDN	1	0	**1**
Service Facilitator	6	5	**11**
Adult Day Health Care	1	1	**2**
Total	**25**	**18**	**43**

The 43 HCBS provider audits conducted by PRU involved providers who had been paid a total of $58,895,795 for the period that the audit reviewed. These audits included claims that represented $7,240,146 in billings and found $3,576,595, or about half of the total audited payments, to be in error. This equates to an average of $83,177 in overpayments identified per audit. It is important to note that the dollar amounts in error in the table are reflective of any reductions resulting from DMAS' policy of allowing providers to submit additional documentation to correct errors identified at the preliminary review stage before a final overpayment letter is issued. A breakout of those figures by fiscal year is displayed in the table below.

Table 11: PRU Audit Findings, FY 2013-2014

Fiscal Year Audit Conducted	Total Audits Conducted	Amount Paid to Audited Providers	Total Dollars Audited	Total Dollars in Error	Percent of Audited Dollars in Error
FY 2013	25	$15,081,155	$3,587,826	$1,537,136	43%
FY 2014	18	$43,814,640	$3,652,320	$2,039,459	56%
Total	**43**	**$58,895,795**	**$7,240,146**	**$3,576,595**	**49%**

While PRU audits in FY 2013 and FY 2014 uncovered around $83,177 in overpayments on average, there was substantial variance from that number in the results of individual audits. Twelve HCBS audits resulted in less than $1,000 in overpayments, with 4 audits identifying no erroneous payments. In addition, only 6 audits resulted in findings of greater than $100,000. The following table gives a breakdown of audit findings by fiscal year.

Table 12: PRU Audits by Amount of Findings, FY 2013-2014

Fiscal Year Audit Conducted	Total Audits Conducted	Total Audits with Findings	Total Audits with findings <$1000	Total Audits with findings $1,000-$10,000	Total Audits with findings $10,000-$100,000	Total Audits with findings >$100,000
FY 2013	25	23	7	3	9	4
FY 2014	18	16	1	5	8	2
Total	**43**	**39**	**8**	**8**	**17**	**6**

The remaining tables provide information on appeals of PRU audits conducted on HCBS providers. The period for providers to appeal the results of FY 2014 audits has not yet concluded, so those incomplete results will not be presented in this report. Instead, this section will present the results of appeals of FY 2013 PRU audits, along with FY 2012 audits to allow for a year-over-year comparison.

Of the 43 audits conducted in FY 2012 and FY 2013 in which there were findings, 10 were appealed to the Informal Fact Finding Conference (IFFC) level. Of those 10 appeals, 3 resulted in a reduction of the overpayment findings of the original audit.

Table 13: Results of IFFC Appeals of PRU Audits, FY 2012-2013

Fiscal Year Audit Conducted	Total Audits with Findings	Total Appealed	Total Dollars Appealed	Total Reduced at IFFC	Total reduction in overpayments (IFFC)
FY 2012	20	4	$97,339	1	$1,486
FY 2013	23	6	$1,175,486	2	$124,257
Total	**43**	**10**	**$1,272,825**	**3**	**$125,743**

After IFFC, the next level of the appeals process is the formal appeal. Five providers appealed to this level, with a total overpayment amount of $341,202 being appealed. None of those five formal appeals resulted in reductions to the overpayments identified in the original audit.

Table 14: Results of Formal Appeals of PRU Audits, FY 2012-2013

Fiscal Year Audit Conducted	Total Formal Decisions	Total Amount Appealed to Formal	Total Audits Reduced at Formal	Total reduction in overpayments (Formal)
FY 2012	2	$34,331	0	$ -
FY 2013	3	$306,871	0	$ -
Total	**5**	**$341,202**	**0**	**$ -**

Conclusion

Over the past years, this advisory committee has provided an opportunity for the HCBS provider community to share their concerns about the DMAS audit process with DMAS staff and contractors. DMAS has worked to understand these concerns and has made several changes to the audit process as a result. The workgroup also provides DMAS an opportunity to share information about regulatory changes affecting audits, and educate providers on the process and findings of audits of Home- and Community-Based Services.

ATTACHMENT I – 2014 Advisory Group Meeting Attendees

AFFILIATION	NAME
Virginia Association for Home Care and Hospice (VAHC)	Marcia Tetterton
Virginia Association of Personal Care Providers (VA-PCP)	Bonnie Gordon
Virginia Association of Community Services Boards (VACSB)	Jennifer Faison (phone)
Virginia Network of Private Providers, Inc (VNPP)	Jennifer Fidura
Virginia Association of Centers for Independent Living (VACILS)	Debbie Fults
Virginia Association of Community Rehabilitation Programs (vaACCSES)	Dave Wilber Karen Tefelski
Virginia Adult Day Health Services Association (VADHSA)	Sue Nutter (phone)
Virginia Association for Hospices & Palliative Care (VAHPC)	Brenda Clarkson
Department of Behavioral Health and Developmental Services (DBHDS)	Gail Rheinheimer
Department of Medical Assistance Services (DMAS)	Louis Elie
	Jeanette Trestrail
	Brad Marsh
	Vanea Preston
	Tracy Wilcox
	KeShawn Harper
	Elizabeth Smith
Myers and Stauffer, LC	JoAnn Hicks Chuck Smith Travis Melton

ATTACHMENT II – HCBS Audit Results by Provider Type

FY 2013 Myers and Stauffer, LC

Provider Type	Total Audits Conducted	Total Dollars Audited	Total Dollars in Error	Percent of Audited Dollars in Error
Adult Day HC	10	$428,801	$135,633	32%
Home Health	12	$379,069	$30,845	8%
Hospice	6	$1,658,979	$106,823	6%
Congregate Living	4	$1,988,988	$1,072,904	54%
Day Support	10	$1,263,239	$337,222	27%
In-Home Residential	8	$4,482,277	$1,481,211	33%
Skilled Nursing	7	$943,069	$183,018	19%
Supported Employment	8	$1,330,403	$678,361	51%
PDN	14	$3,002,415	$437,268	15%
Personal Care	42	$6,595,528	$3,137,880	48%
Respite Care	25	$694,567	$491,547	71%
Service Facilitator	16	$159,884	$97,409	61%
Total	**162**	**$22,927,220**	**$8,190,119**	**36%**

FY 2014 DMAS Provider Review Unit

Provider Type	Total Audits Conducted	Total Dollars Audited	Total Dollars in Error	Percent of Audited Dollars in Error
ID/MR Waiver	4	$2,324,623	$1,439,472	62%
Adult Day Health Care	1	$5,762	$2,073	36%
Personal Care	5	$1,045,628	$409,906	39%
Respite	3	$101,621	$44,612	44%
Service Facilitator	5	$174,686	$143,396	82%
Total	**18**	**$2,039,459**	**$3,652,320**	**56%**