PROVIDER REIMBURSEMENT REVIEW BOARD
HEARING DECISION

2001-D28

PROVIDER -
Southwestern Nursing Home and
Rehabilitation Center
Pittsburgh, PA

Provider No. 39-5742

vs.

INTERMEDIARY -
Blue Cross and Blue Shield Association/
Veritus Medicare Services

DATE OF HEARING-
January 4, 2001

Cost Reporting Periods Ended -
December 31, 1995 and
December 31, 1995

CASE NOs. 97-2018 and 99-0881

INDEX

ISSUES:

1. Were the Intermediary's adjustments reclassifying Director of Nursing and Assistant Director of Nursing costs from the Administrative and General Cost Center to the Nursing Administration Cost Center proper?

2. Were the Intermediary's adjustments reclassifying Social Services costs proper?

3. Were the Intermediary's adjustments reclassifying over-the-counter drug costs and incontinency costs proper?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Southwestern Nursing Home and Rehabilitation Center ("Provider") is a 118 bed skilled nursing facility ("SNF") located in Pittsburgh, Pennsylvania. On May 31, 1996, the Provider submitted its cost report for its fiscal year ended December 31, 1995. Aetna Insurance Company, which was the intermediary at that time, performed a desk review of the Provider's cost report and issued a Notice of Program Reimbursement ("NPR") on January 15, 1997. The NPR contained adjustments reclassifying certain costs pertaining to nursing administration, social services, and over-the-counter drug and incontinency supplies. On March 18, 1997, the Provider appealed these adjustments to the Provider Reimbursement Review Board ("Board") pursuant to 42 C.F.R. §§ 405.1835-.1841, and met the jurisdictional requirements of those regulations. The amount of Medicare funds in controversy is approximately $13,200.[1]

Subsequently, Veritus Medicare Services ("Intermediary") reviewed the Provider's cost report for its fiscal year ended December 31, 1996, and issued an NPR on September 25, 1998.[2] Reflected in this NPR were the same adjustments pertaining to the classification of certain nursing administration costs that were made to the Provider's 1995 cost report. On December 21, 1998, the Provider properly appealed these adjustments to the Board, and met all jurisdictional requirements. The amount of Medicare funds in controversy for this accounting period is approximately $10,200.[3]

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[1] Case No. 97-2018. Intermediary Position Paper at 4. Provider Position Paper at 1.

[2] Veritus Medicare Services became the Provider's Intermediary on July 1, 1997, and prepared the arguments for both years under appeal.

[3] Case No. 99-0881. Provider Position Paper at 1. NOTE- All further references to party position papers contained in this decision pertain to Case No. 97-2018.

The Provider was represented by Stevan P. Gottlieb, CPA, of Gottlieb & Associates, P.C. The Intermediary was represented by James R. Grimes, Esq., Associate Counsel, Blue Cross and Blue Shield Association.

Issue No. 1- Nursing Administration

Facts:

The Provider charged the salary expenses of its Director of Nursing ("DON") and Assistant Director of Nursing ("ADON") to the Administrative and General (A&G) Cost Center where they were allocated through Medicare's cost finding process on the basis of accumulated cost. The Intermediary reclassified these expenses to the Nursing Administration Cost Center for the purpose of Medicare cost finding where they were allocated based upon nursing salaries. See Exhibit I-3 at Adjustment No.1.[4] The effect of the Intermediary's reclassifications is a reduction to the Provider's program payments. That is, because charging these expenses to the A&G Cost Center allocates them to both routine and ancillary services having a greater Medicare utilization than charging them to Nursing Administration where they are allocated only to routine care.

PROVIDER'S CONTENTIONS:

The Provider contends that the Intermediary's adjustments are improper. The Provider asserts that charging the costs of its DON and ADON to the A&G Cost Center provides the most accurate and appropriate allocation of these expenses. The Provider explains that these individuals are responsible for all aspects of patient care in accordance with their job duties and state licensure requirements. Respectively, the A&G Cost Center will properly allocate these costs to all aspects of patient care while the Nursing Administration Cost Center only allocates them to routine service cost centers.[5]

The Provider contends that it is aware of no instruction in the Provider Reimbursement Manual, Parts I or II ("HCFA Pub. 15-1" and "HCFA Pub. 15-2") requiring DON and ADON costs to be charged to the Nursing Administration Cost Center. The Provider believes this matter is further evidenced by instructions at HCFA Pub. 15-2 § 1610, which are used to complete the Nursing Administration line of the cost report, Worksheet A, line 9. These instructions state:

> [t]his cost center normally includes only the cost of nursing administration. The salary cost of direct nursing services

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[4] The Intermediary also reclassified the subject salary expenses used as an allocation statistic on Worksheet B-1 of the Provider's cost reports from A&G to Nursing Administration. See Exhibit I-3 at Adjustment No.12. Intermediary Position Paper at 4.

[5] Provider Position Paper at 3.

> (including the salary cost of nurses who render direct service in more than one patient care area) are directly assigned to the various patient care cost centers in which the services were rendered. Direct nursing services include gross salaries and wages of head nurses, registered nurses, licensed practical and vocational nurses, aides, orderlies, and ward clerks.
>
> However, if your accounting system fails to specifically identify all direct nursing services to the applicable patient care cost centers, then the salary cost of all direct nursing service is included in this cost center.

HCFA Pub. 15-2 § 1610 at line 9. (Emphasis added.)[6]

The Provider contends that the program's instructions are clear; only direct nursing services should be classified to the Nursing Administration Cost Center. And notably, the duties and services provided by the DON and ADON are all-encompassing and are not considered to be direct nursing services in their entirety.

The Provider asserts that the job duties and state licensure requirements of its DON and ADON show that they are responsible for all aspects of patient care. In part, these individuals are responsible for passing department of health inspections, which include housekeeping and the operation of plant (life safety codes), monitoring the dietary needs of the patients, along with direct routine nursing services and ancillary services rendered to patients. They are also responsible for supervising the delivery of direct patient care, the administering of medications and medical supplies, the provision of rehabilitation therapy services and other ancillary services. Their positions involve coordinating with nursing personnel and rehabilitation therapists (both salaried and contracted), pharmacy and medical supply vendors, care plan committees as well as several department heads of the facility, for overseeing the total package of care that residents receive in the facility.[7]

The Provider notes that Intermediary interviews with its DON and ADON indicate that they were involved with the ancillary cost centers. Moreover, notarized affidavits from both the DON and ADON and copies of their job descriptions show that their duties included the supervision and/or oversight of all aspects of care provided to patients, which included both routine and ancillary services.[8]

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[6] Exhibit P-6.

[7] Provider Position Paper at 9

[8] Provider's Post Hearing Brief at 5. Provider's Post Hearing Brief at Exhibits 1 and 2. Transcript ("Tr.") at 44.

The Provider also contends that since the DON and ADON are responsible for all aspects of patient care that apportioning their costs based upon nursing salaries as Nursing Administration costs conflicts with Medicare's prohibition against cost shifting. Specifically, the Provider explains that the Prime Directive in determining costs of Medicare beneficiaries is found at 42 U.S.C. § 1395x(v)(1)(A), which establishes the Cross Subsidization Rule. The Cross Subsidization Rule states that the Secretary, in prescribing the regulations for determining reasonable costs, shall:

> (i) take into account both direct and indirect costs of providers of services. . . in order that, under the methods of determining costs, the necessary costs of efficiently delivering covered services to individuals covered by the insurance programs established by this subchapter will not be borne by individuals not so covered, and the costs with respect to individuals not so covered will not be borne by such insurance programs. . .

42 U.S.C. § 1395x(v)(1)(A).[9]

Accordingly, the Provider asserts that the notion of individuals not so covered bearing the costs applicable to Medicare beneficiaries, and vice versa, is a violation of the Cross Subsidization Rule, which is in turn a violation of the Prime Directive.

Respectively, the Provider explains that HCFA Pub. 15-1 § 2306, Cost Finding Methods, defines cost centers that do not directly generate patient care revenue but are utilized as a service by other departments as "nonrevenue-producing cost centers." At HCFA Pub.15-1 § 2306.1 the manual states that: "all costs of the nonrevenue producing cost centers are allocated to all centers they serve . . ."Id. This concept is reinforced at HCFA Pub. 15-1 § 2307, Direct Assignment of General Service Costs, which requires: "[t]he costs of a general service cost center . . . be allocated to the cost centers receiving service from that cost center."Id. Notably, using gross nursing salaries to allocate Nursing Administration costs only distributes those costs to routine services, whereas, the A&G Cost Center allocates these costs to all aspects of patient care and is clearly more accurate. That is, since many of these costs are undoubtedly, in part, related to the ancillary services that a patient receives, the use of a statistic (i.e., nursing salaries) that only allocates to routine services would cause these costs to be borne by other patients in direct conflict with the Prime Directive.[10]

The Provider notes that the Board has been consistent in its findings and decisions that the Prime Directive, or Cross Subsidization Rule as set forth in 42 U.S.C. § 1395x(v)(1)(A), must be

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[9] Exhibit P-7.

[10] See Exhibit P-10.

adhered to. In making its decisions, the Board recognizes that the Prime Directive overrides the published regulation concerning prior intermediary approval, and recognizes that prior intermediary approval is subordinate to accuracy of cost allocations.[11]

The Provider disagrees with the Intermediary's argument that the DON and ADON should be classified to the Nursing Administration Cost Center in accordance with the Chart of Accounts for Hospitals published by the American Hospital Association ("AHA").[12] The AHA Chart of Accounts is not a regulation and should not be used for purposes of determining reimbursement under the Medicare program. The AHA acknowledges this on page 3 of the Chart of Accounts by stating: "this manual is addressed to the recording and reporting of financial information for management accounting and public reporting purposes, not for reimbursement purposes." Chart of Accounts for Hospitals at 3.[13] Furthermore, the title itself, Chart of Accounts for Hospitals, indicates that this publication is geared primarily towards hospitals and not towards freestanding SNFs such as the Provider. Moreover, the new writers of the Chart of Accounts for Hospitals, published by the Healthcare Financial Management Association, have acknowledged this fact by stating that: "the health care entity to which this book is directed is the hospital enterprise organized and operated either on a not-for-profit or investor-owned basis. . ." Chart of Accounts for Hospitals at 1.[14]

The Provider also argues that while the classification of the DON and ADON to Nursing Administration may be appropriate for a hospital, this treatment would not be appropriate for a freestanding SNF. That is, because the duties and responsibilities of the DON and ADON in a hospital may differ substantially from those in a freestanding SNF. Furthermore, in a hospital setting the Medicare utilization in the routine cost centers is virtually the same as the Medicare utilization in the ancillary cost centers. However, in a SNF the Medicare utilization in the routine cost centers is typically much less than that of the ancillary cost centers. For example, the Provider in this case has a Medicare utilization of 10.08 percent in the routine service cost centers, while the ancillary cost centers have an overall average Medicare utilization of 76.52 percent.[15] Since hospitals do not typically have this disparity in Medicare utilization between routine and ancillary services, the exclusion of ancillary cost centers from the Nursing Administration statistic has virtually no impact on the costs apportioned to the Medicare program for hospitals. However, in a SNF setting the exclusion of ancillary cost centers from the Nursing Administration statistic has a substantial impact of shifting costs away from the

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[11] See Provider Position Paper at 11 for a listing of Board decisions upholding the Cross Subsidization Rule. See also Exhibit P-8.

[12] Provider Position Paper at 12.

[13] Exhibit P-11.

[14] Exhibit P-12.

[15] Exhibit P-13. Tr. at 29.

Medicare program, from the higher Medicare utilizing ancillary cost centers, to the lower Medicare utilizing routine service cost centers.[16]

The Provider contends that if the subject costs must be placed in the Nursing Administration Cost Center, then an appropriate statistical basis should be used to allocate them to all the cost centers which they benefit as required by HCFA Pub. 15-1 § 2307 and the Cross-Subsidization Rule.[17] There are a variety of statistics readily available for this purpose. They include, but are not limited to, Accumulated Costs, Gross Patient Charges, Direct Care Labor Costs - including contracted therapy labor costs.[18] The statistical basis used by the Intermediary, nursing salaries, excluded contracted labor costs and allocated 100 percent of Nursing Administration costs to the routine service cost centers, with no allocation whatsoever to the ancillary cost centers. The Direct Care Labor and Gross Patient Charges statistics provide a more appropriate recognition of the ancillary cost centers served by Nursing Administration. Furthermore, both of these alternative statistics recognize that a vast majority of the time spent by Nursing Administration is with the routine cost centers, in that, the ancillary cost centers compromise only 22.63 percent and 18.44 percent of the Direct Care Labor and Gross Patient Charges statistics, respectively.[19] The limitations imposed by the Intermediary, in that, Nursing Administration should only be allocated to routine cost centers, assumes that Nursing Administration does not spend any time whatsoever overseeing the ancillary cost centers. The Intermediary, by preventing the Provider from allocating any Nursing Administration costs to the ancillary cost centers, causes a substantial shift of costs from the Medicare program to other patients violating the Prime Directive. Since Medicare utilization in the ancillary cost centers is much higher than that of the routine cost centers, the shifting of costs from ancillary to routine services results in less costs allocated to the Medicare program, and higher costs to be borne by other patients.[20]

In all, the percentage of costs allocated to the ancillary cost centers using either the Direct Care Labor or Gross Patient Charges statistic produces a more realistic measure of the utilization of Nursing Administration by ancillary services in comparison to the Intermediary's statistic which allocates 100 percent of Nursing Administration to routine services. And, while the Intermediary may argue that prior written approval would have been needed to make any change to the cost center's statistical allocation base, the Board has been consistent with its rulings that accuracy of allocation is most important. See for example, Florida Life Care, Inc. v. Aetna Life Insurance Co, PRRB Dec. No. 90-D25, May 9, 1990, Medicare and Medicaid Guide ("CCH") ¶ 38,522, decl'd rev., HCFA Administrator, June 12, 1990, where the Board found that even a

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16 Provider's Post Hearing Brief at 2.

17 Provider Position Paper at 13.

18 Exhibit P-10.

19 Id.

20 Exhibit P-13.

timing or deadline requirement in Medicare's manual instructions could not: "prohibit the Provider from using a more accurate cost finding methodology . . . because this methodology is the. . . most accurate method."Id.

The Provider cites Chevron USA Inc., v. Natural Resource Deferment Council, Inc., 467 U.S. (837) 1984 ("Chevron"), and explains that an agency's regulations are given controlling weight unless they are arbitrary, capricious or manifestly contrary to statute. This finding by the Supreme Court is referred to as "Chevron deference." Also, the Provider cites Christenson v. Harris County 529 U.S. 576 (2000) ("Christenson") and explains, in general, that interpretations contained in formats such as opinion letters, policy statements, agency manuals, and enforcement guidelines, do not warrant Chevron's style of deference but may be afforded respect unless they conflict or contrast with existing statutes, rules, etc. And, with respect to these findings, the Provider asserts that the Intermediary's adjustments are clearly improper since the controlling rules are not ambiguous.[21]

In particular, the Provider maintains that HCFA Pub. 15-1 §§ 2306 and 2307 leave no gaps in the allocation rules. According to HCFA Pub. 15-1 § 2306: "[a]ll costs of nonrevenue producing centers are allocated to all centers which they serve."Id. And, HCFA Pub. 15-1 § 2307 states:"[t]he costs of a general service cost center. . . be allocated to the cost centers receiving service from that cost center."Id.

The Provider contends that the Intermediary's reliance upon Medicare's cost reporting instructions, HCFA Pub.15-2 § 1610, to support its position is unfounded. The Provider cites National Medical Enterprises v. Bowen, 851 F.d 2 291 (9th. Cir. 1988), finding that Part II of the manual is never intended to establish Medicare policy and requires no particular deference. The Provider asserts that the Secretary does not dispute the characterization that new policies were promulgated through regulations and occasionally through Part I of the manual, and that Part II is only an instruction to help intermediaries fill out cost reporting forms.[22]

Finally, the Provider contends that the Intermediary refers to/and relies upon program regulations and instructions that have no relationship to cost apportionment. The Provider asserts that the Intermediary's witness agreed that:

> 1. 42 C.F.R. § 483.10(c)(8)(i) does not deal with cost apportionment or step down allocations. Tr. at 47.
>
> 2. 42 C.F.R. § 483.30(b)(2) deals with staffing requirements and does not mention the step down allocation of DON and ADON expenses to ancillary cost centers. Tr. at 49.

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[21] Tr. at 8-12. Provider's Post Hearing Brief at 1.

[22] Provider's Post Hearing Brief at 4. Tr. at 10.

3. HCFA Pub. 15-1 § 2203.1 has nothing to do with the step down process and provides no guidance as to the allocation of nonrevenue producing cost centers to revenue producing cost centers. Tr. at 66.

Accordingly, the Provider concludes that the Board should reverse the Intermediary's adjustments or order that Nursing Administration be allocated on the basis of accumulated cost.

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that its adjustments reclassifying the salary expenses and allocation statistics of the Provider's DON and ADON to the Nursing Administration Cost Center are proper.[23]

The Intermediary contends that the DON and ADON, as managers, precisely meet the description of Nursing Administration found in the instructions for completing the Medicare cost report. Specifically, HCFA Pub 15-2 § 1610, line 9 states:

> Line 9 — This cost center normally includes only the cost of nursing administration. The salary cost of direct nursing services (including the salary cost of nurses who render direct service in more than one patient care area) are directly assigned to the various patient care cost centers in which the services were rendered. Direct nursing services include gross salaries and wages of head nurses, registered nurses, licensed practical and vocational nurses, aides, orderlies and ward clerks.
>
> However, if your accounting system fails to specifically identify all direct nursing services to the applicable patient care centers, then the salary cost of all direct nursing service is included in this cost center.

HCFA Pub 15-2 § 1610, line 9. (Emphasis added.)

The Intermediary notes the manual's instruction that direct nursing services, head nurses, registered nurses, etc., are to be directly assigned to the patient care centers they service. Direct nursing services may be assigned to the Nursing Administration Cost Center if, and only if, the Providers accounting system cannot directly assign those costs.

In addition, the Intermediary asserts that the Provider's job descriptions for the DON and ADON clearly indicate that the salary and related expenses of these individuals should be included in the

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[23] Intermediary Position Paper at 4.

Nursing Administration Cost Center.[24] By the terms of the job descriptions the DON is charged with the responsibility to: "plan, organize, develop and direct the overall operation of our Nursing Services Department." Provider Job Description.[25] And similarly, the ADON is responsible for: "assisting the Director of Nursing Services in the planning, organizing, developing & directing the day-to-day functions of the Nursing Services Department. . . ." Provider Job Description.[26]

The Intermediary rejects the Provider's contention that the DON and ADON should be charged to the A&G Cost Center because they are responsible for all aspects of patient care. The Provider states that the DON and ADON are responsible, in part, for health inspections, which includes housekeeping and the operation of plant (life safety codes), monitoring the dietary needs of the patients, along with direct nursing (routine and ancillary) services rendered to patients.[27] However, the Medicare program would expect the DON to communicate and coordinate with other departments. The DON might work with dietary to ensure a patient's diet is adjusted to meet his or her condition or treatment. However, that does not mean that the DON is responsible for the dietary department. That communication and coordination is part of the routine nursing service the patient receives, and as a result the benefit is to routine nursing service. Similarly, communication with the physical therapy department about a patients progress is not for the purposes of oversight or management of physical therapy services, but to properly coordinate routine nursing services, including understanding a patients progress or ability to ambulate. Accordingly, the kind of association the Provider is describing when talking about coordination of care is not the provision of a benefit to ancillary departments by Nursing Administration.[28]

The Intermediary contends that regulations at 42 C.F.R. § 483.10(c)(8)(i) qualify the point that the subject costs are part of routine charges, and should not be allocated to the ancillary areas of the Medicare cost report. Specifically, 42 C.F.R. § 483.10(c)(8)(i) defines routine services for a Medicare or Medicaid patient as:

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[24] Intermediary's Post Hearing Brief at 2.

[25] Intermediary's Post Hearing Brief at Exhibit 1.

[26] Intermediary's Post Hearing Brief at Exhibit 2.

[27] Intermediary Position Paper at 5.

[28] Intermediary's Post Hearing Brief at 4.

> [d]uring the course of a covered Medicare or Medicaid stay, facilities may not charge a resident for the following categories of items and services:
>
> (A)Nursing services as required at § 483.30 of this subpart.

42 C.F.R. § 483.10(c)(8)(i).

42 C.F.R. § 483.30(b)(2) states:

> [e]xcept when waived under paragraph (c) or (d) of this section, the facility must designate a registered nurse to serve as the DON on a full time basis. . .

42 C.F.R. § 483.30(b)(2).

The Intermediary contends that the AHA recognizes that Nursing Administration includes the DON and ADON. An excerpt form the AHA Chart of Accounts defines the Nursing Administration Cost Center as:

> [o]verall administration and supervision of all nursing services. It includes the work of the director, assistants. . . . Examples of job titles include, director of nurses, assistant director of nurses. . . .

AHA Chart of Accounts for Hospitals.

Finally, the Intermediary contends that the proper statistical base to be used in this instance is one that allocates Nursing Administration costs to the routine areas of the cost report. Program instructions for completing the cost report, HCFA Pub 15-2 § 1313, recommend that Nursing Administration be allocated based upon direct nursing hours of service. This is the most accurate allocation of Nursing Administration costs. Respectively, however, the Provider chose to file its Medicare cost report using nursing salaries as the statistical base for allocating Nursing Administration. This too would be an acceptable allocation basis since Nursing Administration costs would only flow to departments with directly assigned nursing staff.[29]

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[29] Intermediary Position Paper at 6.

Issue No. 2- Social Services

Facts:

The Provider recognized that the time and expense of certain personnel could be classified to the Social Services Cost Center. However, the Provider also recognized that these same individuals spent a significant amount of time working in the patient admitting process. Since the Provider believed this time and effort benefitted all aspects of patient care, it classified the individuals' expenses to the A&G Cost Center where it was allocated to both routine and ancillary services on the basis of accumulated cost. The Intermediary reviewed these expenses and determined that they should be considered only as routine services for the purpose of Medicare reimbursement. Therefore, the Intermediary reclassified these costs from the Provider's A&G Cost Center to the Social Services Cost Center and allocated them through Medicare's cost finding process on the basis of patient days.[30]

PROVIDER'S CONTENTIONS:

The Provider contends that Social Services have evolved over the years into one of the primary functions of a SNF. As such, Social Services costs are indirect costs incurred by a SNF for the benefit of its operation as a whole. Respectively, the Medicare program defines these types of indirect costs as general service costs which are allocated to other cost centers based upon the services rendered to them. However, the allocation statistic recommended for the Social Services Cost Center makes it difficult, if not impossible, to allocate any of these costs to the ancillary cost centers.[31]

Notwithstanding, the Provider contends that certain personnel whose time and salary could be charged to Social Services should be charged to A&G because they spend a significant amount of time working in the patient admitting process. Program instructions at HCFA Pub. 15-1 § 2534.10(A)(5) recognized this, in that they require a reclassification of: "any indirect costs (e.g., social services). . . for purposes of comparison to the peer group."Id.[32] The Provider believes this is consistent with its position. That is, match costs to compare to their "traditional" cost centers for comparison with the Market Basket/Peer Group, but classify the costs in the cost center that provides the most accurate allocation methodology in conformity with 42 C.F.R. § 413.5.

The Provider asserts that its position is further supported by a letter issued by the Acting Associate Regional Administrator, Division of Medicare, Health Care Financing Administration

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30 Provider Position Paper at 3. Intermediary Position Paper at 7.

31 Provider Position Paper at 16.

32 Exhibit P-14.

("HCFA"), on April 25, 1997.[33] In that letter HCFA states: "while there is no prohibition against establishing a separate admissions cost center, HCFA has not granted permission to include admissions cost in the social service cost center." HCFA Letter, April 25, 1997. HCFA also states that: "all costs associated with admissions, must be added to the administrative and general (A&G) cost center."Id. Moreover: "the portion of the salary of employees with cross cutting responsibilities such as clinical care coordinators that is related to admissions must be allocated to A&G cost for purposes of comparison to the peer group. If providers cannot verify the portion of these salaries related to non admissions duties, the entire salary should be deemed admissions related and added to A&G cost for peer group comparison."Id. Respectively, the Provider asserts that it was unable to segregate admissions related costs from its Social Services costs and, therefore, treated all costs as being 100 percent admissions related and classified them to the A&G Cost Center in accordance HCFA's April 25, 1997 letter.

The Provider contends that prior to replacement by new HCFA Pub. 15-1 § 2313.1, former HCFA Pub. 15-1 § 2313.1 was entitled Alternate Method of Allocating Administrative and General Expenses, and allowed providers to establish separate cost centers within the A&G Department, one of which was admitting. The Provider asserts, therefore, that clearly this portion of the subject expenses should be classified in the A&G Cost Center. Furthermore, employees that could be classified in this department document all aspects of patient care. The use of an allocation statistic that would allocate these costs only to routine cost centers would not be in accordance with HCFA Pub. 15-1 § 2307 and 42 C.F.R. § 413.5. The use of the A&G Cost Center would mitigate this problem as it allocates costs to all aspects of patient care.

The Provider contends that gross charges would also be an appropriate basis for allocating the subject costs pursuant to HCFA Pub. 15-1 § 2313.2(A). In part, the manual states: "[w]here the admitting department serves both inpatients and outpatients, gross charges would be an adequate basis for allocation." HCFA Pub. 15-1 § 2313.2(A). Respectively, the Provider notes that its Social Services personnel furnish services to the inpatient department, which includes both routine and ancillary services. Therefore, the methodology of allocating these costs based on gross charges would be appropriate.[34]

The Provider advances the same arguments and contentions pertaining to 42 U.S.C. § 1395x(v)(1)(A), and the Cross Subsidization Rule, as it presented immediately above regarding its DON and ADON costs. In general, the Provider contends that the limitations imposed by the Intermediary, i.e., reclassifying the subject costs to the Social Services Cost Center and allocating them on the basis of patient days results in a shifting of Medicare costs. Under the Intermediary's method the subject costs are allocated only to routine cost centers which incorrectly assumes that Social Services personnel spend no time whatsoever documenting

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[33] Exhibit P-15.

[34] Provider Position Paper at 18.

ancillary services.[35]

The Provider notes the numerous Board findings that the Prime Directive overrides Medicare rules regarding prior intermediary approval. Moreover, the Provider asserts that if the subject costs are to be placed in the Social Services Cost Center, then an appropriate statistical basis should be used so that the costs are allocated to the cost centers receiving service from them as required by HCFA Pub. 15-1 § 2307. The Provider explains that there are a variety of statistics readily available which will allocate these costs to all the cost centers receiving services from these personnel. They include, but are not limited to, Accumulated Costs and Gross Patient Charges. The Gross Patient Charges statistic provides a more appropriate recognition of the ancillary cost centers documented by the Social Services Department. Furthermore, the Gross Patient Charges statistic also recognizes that a vast majority of the time spent by Social Services is with the routine cost centers, in that the ancillary cost centers comprise only 18.44 percent of the Gross Patient Charges Statistics (Exhibit P-10).

The Provider also advances its arguments and contentions discussed above regarding Chevron deference and Christenson with respect to the subject costs.[36] In particular, the Provider asserts that its Social Services Department provides benefit to its patient care services as a whole not just the routine portion. This department also spends a significant amount of time in admissions related duties which are a general service. Accordingly, the Provider asserts that these costs must be apportioned to both routine and ancillary cost centers in accordance with HCFA Pub. 15-1
§§ 2306 and 2307, which are absolutely clear. Pursuant to HCFA Pub. 15-1 § 2306: "[a]ll costs of nonrevenue producing centers are allocated to all centers which they serve."Id. And, HCFA Pub. 15-1 § 2307 states:"[t]he costs of a general service cost center. . . be allocated to the cost centers receiving service from that cost center."Id.

The Provider points out that it allocated approximately 50 percent of its Social Services costs to its A&G Cost Center in 1996, for the admissions related services of that department. This classification was allowed by the Intermediary. The Provider explains that the reason the Intermediary did not allow the same classification in 1995, the subject cost reporting period, is because: "the Provider didn't break out the admitting costs in 95. We basically don't know what they are." Intermediary Testimony, Tr. at 118.[37] The Provider asserts, therefore, that all of the subject costs should be charged to the A&G Cost Center in accordance with HCFA's April 25, 1997 letter.[38]

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35 Id.

36 Provider's Post Hearing Brief at 7.

37 Provider's Post Hearing Brief at 8.

38 Exhibit P-15.

Finally, the Provider contends that by including the subject costs in the A&G Cost Center, or by allocating them on an alternative statistical base, provides a more accurate allocation of these costs, consistent with applicable regulations and prior Board findings.

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that its adjustments reclassifying certain Social Services costs from the Provider's A&G Cost Center to the Social Services Cost Center are proper.

The Intermediary contends that the Provider sought to include the salary costs associated with its Director of Social Services in its A&G Cost Center and to allocate them through Medicare's cost finding process on the basis of total costs. The Intermediary reclassified these costs to the Social Services Cost Center where the recommended allocation statistic is Time Spent.[39] The Intermediary notes, however, that since the Provider did not keep records of Time Spent, it used patient days as the allocation statistic.[40]

Respectively, the Intermediary asserts as it did immediately above regarding the Provider's DON and ADON, that the job description for this position, Director of Social Services, shows that the primary purpose of the position is to plan, organize, develop and direct the operations of the Social Services Department. The Provider's organization chart also indicates that the Director of Social Services has no responsibility for any other unit within the facility.[41]

The Intermediary also contends that Social Services costs are routine in nature and should not be allocated to ancillary cost centers in accordance with program rules.[42] In part, program instructions at HCFA Pub 15-1 § 2203.1, state:

> [t]o reduce the potential impact of unusual or inconsistent charging practices, the following types of items and services, in addition to room, dietary, medical social services, and psychiatric social services, are always considered routine in an SNF for purposes of Medicare cost apportionment. . .

Pub 15-1 § 2203.1.

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39 Exhibit I-9 at Column 13.

40 Intermediary's Post Hearing Brief at 4.

41 Id. See also Intermediary's Post Hearing Brief at Exhibits 3 and 4.

42 Intermediary Position Paper at 7. Tr. at 81.

The Intermediary acknowledges the Provider's argument that its Social Services costs include admitting services which should be included in the A&G Cost Center. Moreover, the Intermediary agrees that where the Provider can identify or split out the admitting costs they could be reclassified to A&G.[43] The Intermediary points out that the Provider did just that in a subsequent year. However, the Provider did not identify the time and costs spent on admitting in the subject cost reporting period, or supply any documentation that would support an allocation of any Social Services costs to admitting. The Intermediary adds that the fact some costs within the Social Services Cost Center may actually relate to the admitting function is not sufficient to support the classification of all Social Services costs to the A&G Cost Center. The Intermediary further contends that it cannot rely upon the split of time in subsequent years to support the same percentage allocation in the year under appeal because there was a significant change (decrease) in the total cost of the Social Services Department.[44]

Issue No. 3- Over-the-Counter Drugs and Incontinency Costs

Facts:

The Provider classified the costs of certain over-the-counter drugs and incontinency supplies to the Nursing Administration Cost Center where they were allocated through Medicare's cost finding process on the basis of direct nursing hours. Since more direct nursing hours are provided in the skilled nursing area of the Provider's facility more of the costs were charged to the Medicare program than if the costs had been allocated on some other basis that would recognize, to a greater degree, the facility's non-skilled areas. The Intermediary reviewed the subject items and disagreed with the Provider's classifications. Therefore, it reclassified the cost of the items to the Central Services & Supply Cost Center where they were allocated on the basis of patient days.

PROVIDER'S CONTENTIONS:

The Provider contends that the Intermediary's adjustments reclassifying the costs of the subject over-the-counter drugs and incontinency supplies from the Nursing Administration Cost Center to the Central Services & Supply Cost Center are improper. The Provider asserts that charging these costs to the Central Services & Supply Cost Center allocates them in a less accurate manner than if they were charged to the Nursing Administration Cost Center.[45]

The Provider contends that HCFA Pub. 15-1 § 2306.1 and HCFA Pub. 15-1 § 2307 require the costs of non-revenue producing cost centers to be allocated to all cost centers which benefit from

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[43] Tr. at 82.

[44] Tr. at 120.

[45] Provider Position Paper at 5.

them. The Provider maintains, therefore, that common sense would seem to indicate that the use of incontinent supplies and over-the-counter drugs is somewhat related to the acuity of the patients being served. Respectively, the Provider argues that the Nursing Administration Cost Center allocates cost utilizing a statistic that measures acuity of patients and the Central Service & Supply Cost Center does not.[46]

The Provider also contends that charging the subject costs to the Nursing Administration Cost Center is consistent with program instructions. In particular, HCFA Pub. 15-2 § 1610, instructions for Worksheet A of the Medicare cost report, line 9, Nursing Administration, states: if your accounting system fails to specifically identify all direct nursing services . . . then the . . . cost . . . is included in this cost center. Id.[47]

Finally, the Provider contends that the Intermediary has essentially agreed with its position regarding this matter. The Provider refers to the Intermediary's Final Position Paper for the Provider's appeal of this same issue in its 1993 cost reporting period. In that paper the Intermediary states that it: "concurs that the original classification by the Provider to include these costs in the Nursing Administration cost center is allowable since all costs were allocated, via the step-down method, to the SNF and NF cost centers which are routine cost centers." Final Position Paper of the Intermediary, Case No. 96-0156, at 5.[48]

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that its adjustments reclassifying the costs of certain over-the-counter drugs and incontinency supplies from the Nursing Administration Cost Center to the Central Services & Supply Cost Center are proper. The Intermediary explains that the Provider classified these expenses to the Nursing Administration Cost Center because it perceives a relationship between the items and supplies and the acuity of patients, i.e., as Nursing Administration costs a greater portion would be allocated to the skilled area of the facility where patients are sicker. The Intermediary, however, contends that the Provider's position is completely unfounded.[49]

The Intermediary contends that the elderly population as a group consumes a large amount of over-the-counter medication. This medication is used to treat relatively minor symptomatic aches and pains that come with their increase in age and correspondingly decline of good health. However, the likely scenario is for an elderly patient in the skilled area of a SNF to ingest fewer over-the-counter drugs and a greater number of prescription drugs considering their condition.

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[46] Provider Position Paper at 35. Provider's Post Hearing Brief at 10.

[47] Exhibit P-6.

[48] Exhibit P-38.

[49] Intermediary Position Paper at 19 and 21. Intermediary's Post Hearing Brief at 6.

Moreover, incontinency supplies are utilized to keep a patient clean. A patient is likely to be administering some kind of incontinent care in their own home prior to an admission to a nursing facility. The continuance of this care is not indicative to the level of skilled nursing care a patient might require in a facility.

Finally, the Intermediary explains that 42 C.F.R. § 413.24 describes adequate cost data and cost finding principles. In part, the regulation states:

> Step-down Method. This method recognizes that services furnished by certain nonrevenue-producing departments or centers are utilized by certain other nonrevenue-producing centers as well as by the revenue-producing centers. All costs of nonrevenue-producing centers are allocated to all centers they serve. . .

42 C.F.R. § 413.24(d)(1).

Respectively, the recommended allocation statistic for the Central Service & Supplies Cost Center is costed requisitions. If the Provider had utilized that recommended basis, the allocation of the subject over-the-counter drugs and incontinency supplies would not be in question, as they would have been allocated based upon their direct usage.

CITATION OF LAW, REGULATIONS AND PROGRAM INSTRUCTIONS:

1. Law - 42 U.S.C.:

§ 1395x(v)(1)(A)	-	Reasonable Cost

2. Regulations - 42 C.F.R.:

§§ 405.1835-.1841	-	Board Jurisdiction
§ 413.5	-	Cost Reimbursement: General
§ 413.24 et seq.	-	Adequate Cost Data and Cost Finding-Cost Finding Methods
§ 483.10(c)(8)(i)	-	Limitation on Charges to Personal Funds
§ 483.30(b)(2)	-	Registered Nurse

3. Program Instructions-Provider Reimbursement Manual, Part I (HCFA Pub. 15-1):

§ 2203.1	-	Routine Services in SNFs
§ 2306	-	Cost Finding Methods
§ 2306.1	-	Step-Down Method
§ 2307	-	Direct Assignment of General Service Costs
§ 2313.1	-	Use of Provider's Unique Cost Centers
§ 2313.2(A)	-	Special Applications-Admitting
§ 2534.10(A)(5)	-	Atypical Direct Cost

4. Program Instructions-Provider Reimbursement Manual, Part II (HCFA Pub. 15-2):

§ 1610	-	Worksheet A - Reclassification and Adjustment of Trial Balance of Expenses
§ 1313	-	Worksheet B, Part I - Cost Allocation - General Service Costs and Worksheet B-1 - Cost Allocation - Statistical Basis

5. Case Law:

Florida Life Care, Inc. v. Aetna Life Insurance Co, PRRB Dec. No. 90-D25, May 9, 1990, Medicare and Medicaid Guide ("CCH") ¶ 38,522, decl'd rev., HCFA Administrator, June 12, 1990.

Chevron USA Inc., v. Natural Resource Deferment Council, Inc., 467 US (837) 1984.

Christenson v. Harris County, 529 U.S. (576) 2000.

National Medical Enterprises v. Bowen, 851 F.d2 291 (9th. Cir. 1988).

6. Other:

Chart of Accounts for Hospitals, L. Vann Seawell

HCFA Letter, April 25, 1997

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board, after consideration of the facts, parties' contentions, evidence presented, testimony elicited at the hearing, and post-hearing submissions, finds and concludes as follows:

Issue No. 1- Nursing Administration

The Provider charged the salary expenses of its DON and ADON to the A&G Cost Center where they were allocated through Medicare's cost finding process on the basis of accumulated cost. The Intermediary reclassified these expenses to the Nursing Administration Cost Center for the purpose of Medicare cost finding where they were allocated based upon nursing salaries. The Provider agrees that the Nursing Administration Cost Center is the natural or most descriptive classification for the subject expenses. However, the Provider argues that classifying these costs to Nursing Administration results in a less accurate allocation or cost finding than classifying them as A&G expenses.

Specifically, the Provider asserts that its DON and ADON are responsible for all aspects of patient care. Therefore, their costs should be allocated to both routine and ancillary cost centers for the purpose of determining Medicare reimbursement. The Provider explains that this allocation is not achieved through the Nursing Administration Cost Center because its allocation statistic, nursing salaries, only allocates costs to routine services. In contrast, the A&G Cost Center does allocate costs to both routine and ancillary care.

The Board finds that the key aspect of this issue is matching the services of the Provider's DON and ADON to the proper allocation statistic. Program instructions at HCFA Pub. 15-1 § 2306.1 state in part: " [a]ll costs of nonrevenue-producing centers are allocated to all centers which they serve. . . .Id.

The Board also finds that the principal evidence in this case regarding the responsibilities of the Provider's DON and ADON are copies of the individuals' job descriptions and a copy of the Provider's Organizational Chart. The Provider did pose the use of alternative allocation statistics including Gross Patient Charges and Direct Care Labor to achieve its desired result. However, the Provider failed to show how the use of an alternative allocation statistic is indicative of the services furnished by its DON and ADON, or factually results in a more accurate allocation than the nursing salaries statistic used by the Intermediary. The Board notes

that the Provider's DON and ADON were not present at the hearing to offer direct testimony.

The Board concludes that the burden of proving that the subject DON and ADON are responsible for all aspects of patient care, including ancillary services, clearly rests with the Provider, and that the evidence presented does not adequately support the Provider's case.

The Board's review of the Provider's job descriptions finds that the DON and ADON may, in fact, furnish services to the ancillary cost centers; at least it seems plausible or does not exclude that possibility. However, more substantive documentation such as time and activity reports, for example, would be necessary to determine the actual nature of those services and the extent to which they are provided. Without further documentation the Board cannot determine if the DON's and ADON's involvement with other individuals within the Provider's organization is that of oversight or whether it is of a fundamental nature one would expect from the heads of the nursing department to exert in carrying out expected nursing activities.

Similarly, the Board finds that a review of the Provider's Organizational Chart does not support the Provider's position. Essentially, the chart shows that the DON and ADON have functional responsibility only for direct nursing services. The chart shows that all department heads, including the DON and ADON, report directly to the Provider's Administrator.

The Board rejects the Provider's argument that only direct nursing services should be charged to the Nursing Administration Cost Center pursuant to Medicare's cost reporting instructions at HCFA Pub. 15-2 § 1610. The Board does not find the Provider's construction of those instructions persuasive.

Finally, the Board rejects the Provider's argument that failure to allocate the costs of its DON and ADON to the ancillary cost centers shifts costs away from the Medicare program in violation of the Cross Subsidization Rule. This argument is contingent upon a finding that the DON and ADON are responsible for all aspects of patient care which has not been proven.

Issue No. 2- Social Services

The Provider classified certain Social Services costs to its A&G Cost Center so they would be allocated to both routine and ancillary cost centers through Medicare's cost finding process. The Intermediary, however, reclassified these costs back to the Social Services Cost Center where they were allocated only to the Provider's routine services cost centers for the purpose of determining Medicare reimbursement.

The Provider, relying in part upon HCFA Pub. 15-1 § 2306.1 ("all costs of nonrevenue-producing centers are allocated to all centers which they serve"), presents two fundamental arguments. First, the Provider argues that its classification is appropriate since its Social Services Department provides benefit to patient care services as a whole, not just to the routine services portion. Notwithstanding, the Provider asserts that its Social Services Department spent a great deal of time performing admissions related functions which clearly should be charged to

the A&G Cost Center. The Provider points out that the Intermediary allowed approximately 50 percent of its Social Services costs to be charged to the A&G Cost Center in 1996, for the admissions related activities.

Regarding the Provider's first argument, the Board finds no evidence in the record demonstrating that Social Services, as a category of activities, benefits all aspects of patient care. Accordingly, the Board rejects the presumption that Social Services costs should be categorically allocated to both routine and ancillary cost centers.

Regarding the Provider's second argument, the Board agrees that the costs associated with Social Services personnel performing admissions related activities can be charged to the A&G Cost Center. The Intermediary also does not dispute this argument.

However, the Board also agrees with the Intermediary, in that a provider must be able to distinguish or split out the admitting portion of its Social Services expenses in order to classify them to the A&G Cost Center. Moreover, with respect to the instant case, the Provider did not distinguish or split out its Social Services admitting costs in the subject cost reporting period. Although the Provider presented its argument, it furnished no evidence showing the amount of its Social Services costs dedicated to admissions related activities.

Finally, the Board agrees with the Intermediary, in that it would not be appropriate to allow the Provider to claim Social Services admitting costs in the subject 1995 cost reporting period based upon the Provider's experience in 1996. That is, by determining the ratio of Social Services admitting costs to total Social Services costs incurred in 1996, and applying that ratio to the Provider's 1995 Social Services expenses. Essentially, the Board finds no evidence in the record indicating that the two reporting periods are similar. In fact, the evidence shows that the Social Services activities furnished by the Provider in 1996, are very much different from those furnished in 1995. In 1995, the Provider incurred approximately $43,000 in Social Services expenses. However, in 1996, those expenses decreased to about $8,800. In all, the Board concludes that the Intermediary's reclassifications are proper.

Issue No. 3- Over-the-Counter Drugs and Incontinency Costs

The Provider classified the costs of certain over-the-counter drugs and incontinency supplies to the Nursing Administration Cost Center so they could be allocated through Medicare's cost finding process on the basis of direct nursing hours. The Provider asserts that direct nursing hours results in an accurate allocation of these expenses because they are a measurement of patients acuity and because the subject drugs and supplies relate to patient acuity. The effect of the Provider's classification is an increase in the allocation of costs to the skilled area of its facility where Medicare patients reside.

The Intermediary concluded that the subject drugs and supplies were routine in nature, and reclassified their costs to the Central Services & Supplies Cost Center where they were allocated based upon patient days. In contrast to the Provider's arguments, the Intermediary asserts that

incontinency is not indicative of level of care, and the likely scenario is for elderly patients in the skilled area of a SNF to ingest fewer over-the-counter drugs and a greater number of prescription drugs considering their condition. The Intermediary notes that costed requisitions is the recommended allocation statistic for the Central Services & Supplies Cost Center but that data was not available from the Provider's records for use in the subject cost reporting period.

The Board finds that the Intermediary's adjustments are proper. As discussed above, the Provider is burdened with the responsibility to prove with substantive evidence that its position is correct pursuant to established rules and regulations. With respect to the relationship that may or may not exist between the use of over-the-counter-drugs and incontinency supplies and patient acuity, the Provider furnished no such evidence. Most significantly, the Provider relies upon presumed logic as the indicator of which patients use the greater portions of these items.

The Board acknowledges but rejects the Provider's reliance upon the fact that the Intermediary allowed the cost of incontinency supplies to be charged to its Nursing Administration Cost Center in 1993. Although that issue had been included in an appeal to the Board, that case was resolved by the parties and withdrawn from the Board's docket. Accordingly, the facts and circumstances surrounding that intermediary adjustment, which may or may not be relevant to the instant case, are unknown.

DECISION AND ORDER:

Issue No. 1- Nursing Administration

The Intermediary's adjustments reclassifying the costs of the Provider's DON and ADON from the A&G Cost Center to the Nursing Administration Cost Center are proper. The Intermediary's adjustments are affirmed.

Issue No. 2- Social Services

The Intermediary's adjustments reclassifying the subject Social Services costs from the Provider's A&G Cost Center to the Social Services Cost Center are proper. The Intermediary's adjustments are affirmed.

Issue No. 3- Over-the-Counter Drugs and Incontinency Costs

The Intermediary's adjustments reclassifying the costs of certain over-the-counter drugs and incontinency supplies from the Provider's Nursing Administration Cost Center to the Central Services & Supplies Cost Center are proper. The Intermediary's adjustments are affirmed.

Board Members Participating:

Irvin W. Kues
Henry C. Wessman, Esq.
Martin W. Hoover, Jr. Esq.
Charles R. Barker
Stanley J. Sokolove

Date of Decision: May 11, 2001

FOR THE BOARD:

Irvin W. Kues
Chairman