PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

ON THE RECORD
2003-D10

PROVIDER –
Christ the King Manor
DuBois, Pennsylvania

Provider No. 39-5460

vs.

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

DATE OF HEARING -
October 24, 2002

Cost Reporting Period Ended
June 30, 1998

CASE NO. 00-3413

INDEX

ISSUES:

1. Was the Intermediary's reclassification of Staff Development Coordinator salaries proper?

2. Was the Intermediary's reclassification of Social Services salaries proper?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Christ the King Manor ("Provider") is a 160-bed skilled nursing facility ("SNF") located in DuBois, Pennsylvania. During its Medicare cost reporting period ended June 30, 1998, the Provider incurred costs typical to SNF operations including Staff Development Coordinator costs and Social Services costs. Veritus Medicare Services ("Intermediary") reviewed the Provider's cost report for this period and concluded that the Provider misclassified its Staff Development Coordinator costs and Social Service costs to the Administrative and General ("A&G") Cost Center. Accordingly, the Intermediary perfected cost report adjustments reclassifying the Provider's Staff Development Coordinator costs to the Nursing Administration Cost Center, and reclassified the Provider's Social Services costs to a Social Services Cost Center where "patient days" were used for cost allocation purposes.

On March 10, 2000, the Intermediary issued a Notice of Program Reimbursement reflecting the subject adjustments. On July 7, 2000, the Provider timely appealed the 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 $17,000.[1]

The Provider was represented by Samuel L. Arena, CPA, of Gottlieb and Associates, P.C. The Intermediary was represented by Bernard M. Talbert, Associate Counsel, Blue Cross and Blue Shield Association.

Issue No. 1 - Staff Development Coordinator Costs:

PROVIDER'S CONTENTIONS:

The Provider contends that the Staff Development Coordinator function benefits all of its facility's departments not just the nursing department. Accordingly, the Provider asserts that the Intermediary's reclassification is improper because charging these costs to the Nursing Administration Cost Center means that they are allocated only to the routine service areas on the Medicare cost report and none are allocated to the ancillary cost centers even though they also received benefit from them.[2]

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[1] Intermediary Position Paper at 2, 5, and 7. Provider Position Paper at 1.

[2] Provider Position Paper at 5.

The Provider asserts that no program instruction requires Staff Development Coordinator costs to be charged to Nursing Administration. Rather, the Provider argues that program instructions contained in the Provider Reimbursement Manual, Part II ("HCFA Pub. 15-2") § 3516, line 9, which is the cost reporting instruction for the Nursing Administration Cost Center, make no mention of Staff Development Coordinator costs. The manual states:

> [t]his 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 cost centers, then the salary cost of all direct nursing service is included in this cost center.

HCFA Pub. 15-2 § 3516, line 9 (emphasis added).

The Provider argues that this instruction clearly specifies that only direct nursing services should be classified to the Nursing Administration Cost Center. This is reinforced by the fact that the statistical basis for allocating this cost center includes only routine service cost centers, and not the ancillary cost centers.

The Provider contends that the educational responsibilities of the Staff Development Coordinator function show that it benefits all other departments and relates to all aspects of patient care. The Provider asserts that Staff Development Coordinator personnel must possess extensive knowledge of state and federal regulations specific to long-term care. Their duties involve training all personnel in the facility on various issues which affect the daily operations of multiple departments. Their main responsibility is to oversee the general safety of the employee and resident populations within the facility. Some of the duties of the Staff Development Coordinator include:

- Development of self-learning modules for employees
- Development and evaluation of Competency Based Assessments
- Development and evaluation of a process of remediation for correcting employee compliance problems
- Clinical trials of various products, including resident supplies, wound dressings, etc.
- Quality Assurance Activities

The Staff Development Coordinator is also required to develop and conduct presentations on various topics for the education of all personnel in the facility. These presentations normally cover the following topics:

Infection control standards under OSHA guidelines
Review of facility policies and procedures manuals
Informing employees of the risks associated with exposure to hazardous materials and contaminants
Employee Health Programs
Resident Rights
Medication Administration
Nursing and General Documentation
Incident Reporting and Resident Safety
Resident Restraints Policies and Procedures
Resident seating arrangements during meals
Resident positioning, body mechanics, and protective and assistive devices
Fire Safety and Review of Fire Escape Plan
Security Issues
Disaster Planning
Pest Control
Handling of soiled linens
Containment of hazardous spills
Disinfection of Equipment
Kitchen cleaning and maintenance
Waste materials disposal (i.e. syringes)

The Provider contends that because the Staff Development Coordinator function clearly benefits all aspects of its facility and all aspects of patient care, that allocating Staff Development Coordinator costs only to the routine service cost areas, as argued by the Intermediary, directly conflicts with Medicare's cross subsidization rule. The Provider explains that the most fundamental of Medicare laws in determining the cost of services furnished to Medicare beneficiaries, i.e., a "Prime Directive," is set forth at 42 U.S.C. § 1395x(v)(1)(A). In part, this law explains that the Secretary of Health and Human Services, in prescribing 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 . . ." Id. Accordingly, the Provider asserts that the application of any manual guideline which results in non-Medicare patients bearing the costs applicable to Medicare beneficiaries, as with the Intermediary's reclassification of Staff Development Coordinator costs, is a violation of this statute.

The Provider asserts that the Board has been consistent in its findings that the cross subsidization rule must be enforced. The Provider adds that the Board recognizes that the Prime Directive overrides published regulations concerning "prior intermediary approval," and recognizes that prior intermediary approval is subordinate to the "accuracy of allocation."[3]

The Provider notes that Part I of HCFA Pub. 15 ("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: "[a]ll costs of nonrevenue-producing centers are allocated to all centers they serve …." Id. Moreover, the Provider asserts that this concept is reinforced at HCFA Pub. 15-1 § 2307, Direct Assignment of General Service Costs, which requires that "[t]he costs of a general service cost center ... be allocated to the cost centers receiving service from that cost center." Id. Respectively, the Provider argues that the Intermediary's reclassification of Staff Development Coordinator costs results in a 100 percent allocation of these costs to the routine service areas, whereas, the A&G Cost Center allocates these costs to all aspects of patient care and is clearly more accurate. Since many of these costs are undoubtedly related to the general and ancillary service cost centers, the allocation of these costs only to the routine service areas would cause these costs to "be borne by other patients," a direct conflict with 42 C.F.R § 413.5 as well as the Prime Directive at 42 U.S.C. § 1395x(v)(1)(A).

The Provider rejects the Intermediary's argument that Staff Development Coordinator costs should be classified to the Nursing Administration Cost Center based upon the Chart of Accounts for Hospitals published by the American Hospital Association ("AHA"). The Provider asserts that AHA's Chart of Accounts is not a regulation and should not be used for purposes of determining Medicare reimbursement. The Provider notes that the AHA acknowledges this fact 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." AHA Chart of Accounts.[4] Furthermore, the Provider adds, the title itself, Chart of Accounts for Hospitals, indicates that this publication is geared primarily towards hospitals not freestanding SNFs such as the Provider. The Provider asserts that the new writers of the Chart of Accounts for Hospitals, published by the Healthcare Financial Management Association ("HFMA"), have also acknowledged this fact on Page 1 of their publication by stating: "the healthcare 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 (HFMA).[5] The Provider cites Extendicare 1996 Insurance Allocation Group v. United Government Services, PRRB Dec. No. 2000-D88, September 26, 2002, Medicare & Medicaid Guide (CCH) ¶ 80,573, decl'd rev., CMS Administrator, November 20,

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[3] See Provider Position Paper at 8 for cites to Board decisions referencing Medicare's cross subsidization rule.

[4] Exhibit P-9.

[5] Exhibit P-10.

2000, where the Board concluded that AHA's Chart of Accounts "has no applicability in situations where Medicare policy has been established . . ." Id. Accordingly, while the classification of Staff Development Coordinator costs to the Nursing Administration Cost Center may be appropriate for a hospital, this treatment would not be appropriate for a freestanding SNF. The duties and responsibilities of the Staff Development Coordinator function in a hospital may differ substantially from those in a freestanding SNF. Furthermore, in a hospital setting Medicare utilization in the routine service cost centers is virtually the same as the Medicare utilization in the ancillary cost centers. However, in a SNF setting Medicare utilization in the routine cost centers is typically much less than that of the ancillary cost centers. For example, the Provider's Medicare utilization is 9.72 percent in its routine cost centers while its ancillary cost centers have an overall average Medicare utilization of 95.45 percent.[6] The Provider asserts, in all, since hospitals do not typically have this disparity in Medicare utilization, the exclusion of ancillary cost centers from the Nursing Administration allocation statistic has virtually no impact on the costs apportioned to the Medicare program. 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 Medicare Program. Therefore, while the Nursing Administration Cost Center may be the appropriate classification for Staff Development Coordinator costs, the statistical basis must meet the requirements of HCFA Pub. 15-1 §§ 2306 and 2307 by allocating costs to all cost centers receiving service from that cost center; proper cost center classification is meaningless if the statistical basis used for cost allocation does not properly allocate costs to all other cost centers receiving benefit from that cost center.

Accordingly, the Provider contends that if the Intermediary finds it necessary to place Staff Development Coordinator costs in the Nursing Administration Cost Center, then an appropriate statistical base should be used so that they are allocated to all of the cost centers receiving benefit from them.[7] The Provider asserts there are a variety of statistics readily available to achieve this objective. They include, but are not limited to, Accumulated Costs, Gross Patient Charges, and Direct Care Labor Costs - including contracted therapy labor costs. The statistical basis used by the Intermediary, direct nursing hours of service, excluded contracted labor costs and allocated 100 percent of Nursing Administration costs to the routine service cost centers, with no allocations whatsoever to the ancillary cost centers.[8]

The Provider believes that the Direct Care Labor and Gross Patient Charges statistics provide the most appropriate recognition of the ancillary cost centers served by Nursing Administration. The Provider believes that both of these alternative statistics also recognize that a vast majority of the time spent by Nursing Administration is with the routine cost centers, in that the ancillary cost centers comprise only 13.80 percent and 16.19 percent of the Direct Care Labor and Gross Patient Charges statistics, respectively.[9] The Provider explains that the limitations imposed by

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6 Exhibit P-6.

7 Provider Position Paper at 11.

8 See Exhibit P-7.

the Intermediary, whereby Nursing Administration costs would 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 of the Medicare program to be borne by other patients, a violation of the Prime Directive. 42 U.S.C. §1395x(v)(1)(A). The Provider notes that since Medicare utilization in the ancillary cost centers is much higher than that in the routine service cost centers, shifting costs from ancillary to routine cost centers (from higher Medicare utilization cost centers to lower Medicare utilization cost centers) results in less costs allocated to the Medicare program, and higher costs being borne by other patients.

The Provider disagrees with any argument the Intermediary may make regarding "prior written approval" needed to change a cost center's allocation base.[10] The Provider explains that the Board has been consistent with its rulings that accuracy of allocation is of most importance. The Provider cites Florida Life Care, Inc. v. Aetna Life Insurance Co., PRRB Dec. No. 90-D25, May 9, 1990, Medicare & Medicaid Guide (CCH) ¶ 38,522, decl'd rev., CMS Administrator, June 12, 1990, where the Board found that even a timing requirement contained in program manual instructions (HCFA Pub. 15-1) could not "prohibit the Provider from using a more accurate cost finding methodology ..., because this methodology is the ... most accurate method."

The Provider also cites Sunbelt Health Care Centers Group v. Aetna Life Insurance Co., PRRB Dec. No. 97-D13, December 3, 1996, Medicare & Medicaid Guide (CCH) ¶ 44,923, decl'd rev., CMS Administrator, January 14, 1997, where the Board makes reference to a letter issued by the Centers for Medicare & Medicaid Services (formerly the Health Care Financing Administration "HCFA") dated March 31, 1995, which reinforced the Board's decision regarding "prior written approval." In pertinent part, CMS states:

> [f]inally, you are concerned that the provider ignored a threshold requirement of PRM section 2307 by failing to obtain prior approval from the fiscal intermediary to use direct assignment of costs. While we [CMS] believe that this is an important requirement that should not be ignored by providers, our enforcement of this requirement has been reshaped by practical considerations. We have never been sustained on appeal in situations where failure to obtain prior written approval is the only defect in a provider's use of a cost allocation alternative. The PRRB has adopted a "no harm, no foul" approach to enforcing this requirement. That is, as long as the provider's cost allocation alternative produces a more appropriate and more accurate allocation of cost, and is supported by adequate, auditable documentation, the provider's alternative has been accepted. We believe that further appeals based solely on the lack of prior approval would be futile. Therefore, you may

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9 Id.

10 Provider Position Paper at 12.

> advise Blue Cross of California (BCC) that, if a particular cost allocation alternative elected by a provider under section 2307 results in a more appropriate and more accurate allocation of cost, is supported by adequate, auditable documentation, and meets all the other requirements of section 2307, BCC may accept the provider's alternative, notwithstanding the lack of prior approval.

CMS Letter, March 31, 1995.

In summary, the Provider contends that an alternative to changing the Nursing Administration's allocation statistic would be to reclassify Staff Development Coordinator costs from the Nursing Administration Cost Center to the A&G Cost Center.[11] Since A&G costs are allocated to all aspects of patient care via the accumulated cost statistic, a portion of these costs would be allocated to the ancillary departments in accordance with HCFA Pub. 15-1 §§ 2306 and 2307. Accordingly, the issue in this case is not whether Nursing Administration is the proper classification for Staff Development Coordinator costs, nor is it whether the Provider needs to obtain prior approval to change the statistical allocation base for the Nursing Administration Cost Center. Rather, the Provider contends that the issue is that any classification or statistic which prohibits the allocation of Staff Development Coordinator costs to the ancillary departments will undoubtedly shift Medicare beneficiary costs to non-Medicare patients, and will violate the cross subsidization rule defined at 42 U.S.C. § 1395x(v)(1)(A) regardless of whether that classification or statistic complies with program instructions.

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that it is appropriate to charge Staff Development Coordinator costs to the Nursing Administration Cost Center.[12] The Intermediary asserts that it reviewed the job description for the Staff Development Coordinator function and found that it reports directly to the Director of Nursing, whose costs are reported in the Nursing Administration Cost Center.[13]

The Intermediary explains that, according to the job description, Staff Development Coordinator duties seem to encompass a number of areas of the facility.[14] However, the Provider has not offered support for its claim that the Staff Development Coordinator function has responsibilities in all departments. The Intermediary further asserts that an analysis of time records would help support the Provider's claim. However, absent that information, the Nursing Administration

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11 Provider Position Paper at 14.

12 Intermediary Position Paper at 7.

13 Exhibit I-10.

14 Exhibit I-11.

15 Provider Position Paper at 1.

Cost Center is the most appropriate classification for Staff Development Coordinator costs.

Issue No. 2 - Social Services Costs:

PROVIDER'S CONTENTIONS:

The Provider explains that the Intermediary made an adjustment reclassifying its Social Services costs from the A&G Cost Center to a Social Services Cost Center. The Provider further explains that the Intermediary then allocated these costs based upon "patient days." The Provider contends that these adjustments are improper because they result in all Social Services costs being allocated to the routine service cost centers with none being allocated to the ancillary cost centers reducing Medicare reimbursement.[15]

The Provider contends that Social Services is one of the primary functions of a SNF. The reimbursable cost of a SNF includes both direct and indirect costs. Program rules define indirect costs as general service costs which are operated for the benefit of the institution as a whole. Program instructions dictate that general service cost centers, one of which is Social Services, may render services to other general service areas as well as to special or patient care departments, and the costs incurred for these cost centers are allocated to other cost centers on the basis of services rendered.[16]

Notwithstanding, the Provider contends that a significant amount of time is spent by personnel in the admitting process that could be classified as Social Services. The Provider cites a CMS Regional Office letter dated April 25, 1997, which states, in part:

> [w]hile 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. . . . all costs associated with admissions, must be added to the administrative and general (A&G) cost center . . . . 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.

CMS Letter, April 25, 1997.[17]

The Provider contends, therefore, that since many of the duties and responsibilities of its Social

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[16] Provider Position Paper at 15.

[17] Exhibit P-13.

Services personnel involve the admissions process, these costs were properly classified to the A&G Cost Center in accordance with CMS' April 25, 1997 letter.

The Provider adds that HCFA Pub. 15-1 § 2313.1, entitled Alternate Method of Allocating Administrative and General Expenses, allows providers to establish separate cost centers within the administrative and general department, one of which was admitting. The Provider asserts, therefore, that this portion of costs, i.e., admitting, should be classified, by regulation, to the A&G Cost Center. Further, the Provider asserts that employees that could be classified in this department document all aspects of patient care. Accordingly, the use of a statistic that would allocate these costs to only the routine cost centers, such as patient days used by the Intermediary, would not be in accordance with HCFA Pub. 15-1 § 2307 and regulations at 42 C.F.R. § 413.5. The use of the A&G Cost Center mitigates this problem as it allocates costs to all aspects of patient care.

The Provider asserts that program instructions also recognize that admitting costs should be allocated to both routine and ancillary cost centers. The Provider notes HCFA Pub. 15-1 § 2313.2(A), which states in part: "where the admitting department serves both inpatients and outpatients, gross charges would be an adequate basis for allocation." Id. The Provider adds that its Social Services personnel service the inpatient department, which includes both routine and ancillary services. Therefore, the methodology for allocating these costs based on gross charges would be an appropriate and accurate basis for allocation in accordance with HCFA Pub. 15-1 § 2307.

The Provider also contends that because its Social Services function benefits various aspects of its facility and patient care, that allocating Social Services costs only to the routine service cost areas, as argued by the Intermediary, directly conflicts with Medicare's cross subsidization rule.[18] The Provider's arguments regarding this matter are identical to the cross subsidization arguments presented by the Provider directly above under the "Staff Development Coordinator" caption. They include reference to Board findings enforcing the cross subsidization rule, noting that the "Prime Directive" overrides published regulations concerning prior intermediary approval, and recognizing that prior intermediary approval is subordinate to the accuracy of cost allocations.

Accordingly, and also in line with the Provider's arguments regarding its Staff Development Coordinator function, the Provider contends that if the Intermediary finds it necessary to place its Social Services costs in a Social Services Cost Center, then an appropriate statistical allocation base should be used so these costs are allocated to all cost centers which receive benefit from them. HCFA Pub. 15-1 § 2307. The Provider asserts there are a variety of statistics readily available to accomplish this objective. They include, but are not limited to, Accumulated Costs and Gross Patient Charges. The Provider explains that the statistical basis used by the Intermediary, patient days, allocates all Social Services costs to the routine service cost centers. 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

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[18] Provider Position Paper at 17.

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 16.19 percent of the Gross Patient Charges statistic.[19] The limitations imposed by the Intermediary, in that Social Services should only be allocated to routine service cost centers, assumes that Social Services personnel do not spend any time whatsoever documenting ancillary services. The Intermediary, by preventing the Provider from allocating any Social Services costs to the ancillary cost centers, results in a substantial shift of costs from the Medicare program to be borne by other patients, a violation of the Prime Directive.

In conclusion, the Provider contends that any classification or statistic which prohibits the allocation of Social Services costs or personnel to the ancillary departments will undoubtedly shift Medicare beneficiary costs to non-Medicare patients in violation of Medicare's cross subsidization rule.

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that its adjustment reclassifying Social Services costs from the A&G Cost Center to the Social Services Cost Center and allocating them on the basis of patient days is proper.[20] The Intermediary contends that HCFA Pub. 15-1 § 2203.1 specifically discusses Social Services as a routine service cost, as follows:

> [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 . . .

HCFA Pub. 15-1 § 2203.1.

The Intermediary asserts that Social Services are performed to meet the needs of patients admitted to a SNF and are primarily performed as part of the routine care of a patient. The Intermediary also contends that "gross patient charges" is not the proper allocation basis for Social Services costs.[21] The Intermediary asserts that the purpose of allocating general service cost centers to revenue-producing cost centers via the step-down methodology is to properly determine the total cost of a service or item. With respect to the instant case, the Provider is advocating a statistical base that would distribute the cost of the Social Services Cost Center to ancillary cost centers and non-reimbursable cost centers as well as to routine cost

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19 Exhibit P-7.

20 Intermediary Position Paper at 5.

21 Id.

centers. However, the Provider has offered no evidence to support a relationship of its Social Services department to these other (ancillary/non-reimbursable) cost centers.

The Intermediary asserts that HCFA Pub. 15-2 § 3524, instructs providers on completion of Worksheet B, Part I, and Worksheet B-1 of the Medicare cost report. In part, these instructions state "[t]he statistical bases shown at the top of each column on Worksheet B-1 is the recommended basis of allocation of the cost center indicated." Id. Worksheet B-1 shows that the recommended basis of allocation of Social Services is Time Spent. The Intermediary asserts that the Provider has not offered support of this Time Spent cost allocation statistic, but believes that Social Services costs should be allocated to all cost centers. An analysis of time records would help support the Provider's claim. Absent this information, an allocation based on patient days would most appropriately allocate the cost of this routine related service.

The Intermediary acknowledges the Provider argument that "a significant amount of time is spent, by personnel that could be classified to this department, in the admitting process of a patient."[22] The Intermediary asserts that while this claim could be true, the Provider has not offered any credible support. The Intermediary maintains, in fact, that Provider Exhibit P-7 (Exhibit I-9) contains statistics showing "hours of service" only going to the routine service areas. The Intermediary asserts, again, that absent supporting documentation the proper allocation should be based upon patient days.

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	-	Apportionment of Allowable Costs

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

§ 2203.1	-	Routine Services in SNFs
§ 2306 et seq.	-	Cost Finding Methods
§ 2307	-	Direct Assignment of General Service Costs

[22] Exhibit I-8.

§ 2313.1	-	Alternate Method of Allocating Administrative and General Expenses
§ 2313.2(A)	-	Special Applications-Admitting

3. Program Instructions-Provider Reimbursement Manual, Part II (HCFA Pub. 15-2

3516 (Line 9)	-	Worksheet A – Reclassification and Adjustment of Trial Balance of Expenses
§ 3524	-	Worksheet B, Part I-Cost Allocation-General Service Costs and Worksheet B-1-Cost Allocation-Statistical Basis

5. Case Law:

Extendicare 1996 Insurance Allocation Group v. United Government Services, PRRB Dec. No. 2000-D88, September 26, 2002, Medicare & Medicaid Guide (CCH) ¶ 80,573, decl'd rev., CMS Administrator, November 20, 2000.

Sunbelt Health Care Centers Group v. Aetna Life Insurance Co., PRRB Dec. No. 97-D13, December 3, 1996, Medicare & Medicaid Guide (CCH) ¶ 44,923, decl'd rev., CMS Administrator, January 14, 1997.

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

6. Other:

American Hospital Association Chart of Accounts for Hospitals.

Healthcare Financial Management Association Chart of Accounts for Hospitals.

CMS Letter, March 31, 1995.

CMS Letter, April 25, 1997.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board, after consideration of the facts, parties' contentions, and evidence presented, finds and concludes as follows:

Issue No. 1 – Staff Development Coordinator Costs

The Provider charged the costs of its Staff Development Coordinator function to its A&G cost center. As an A&G expense these costs were allocated to both routine and ancillary cost centers on the Provider's cost report for the purpose of determining Medicare reimbursement. The Intermediary, however, reviewed these costs and concluded that they were entirely routine in nature and none should be allocated to the ancillary cost centers. Respectively, the Intermediary perfected an adjustment reclassifying the Provider's Staff Development Coordinator costs to the Nursing Administration Cost Center.

In general, the Provider argues that the Staff Development Coordinator function benefits all aspects of patient care and, therefore, its costs should be allocated to both routine and ancillary cost centers pursuant to HCFA Pub. 15-1 § 2306.1, which states in part: [a]ll costs of nonrevenue-producing cost centers are allocated to all cost centers they serve . . . ." The Provider further asserts that this allocation can be accomplished by either classifying Staff Development Coordinator costs to the A&G Cost Center or by changing the allocation basis to recognize both routine and ancillary services if some other classification is used.

For the most part, the Intermediary based its adjustment on the fact that the Staff Development Coordinator reports to the Director of Nursing, whose costs are reported in the Nursing Administration Cost Center. However, the Intermediary acknowledges that the job description for the Staff Development Coordinator function "seems to encompass a number of areas of the facility . . . [and] An analysis of time records would help to support the Provider's claim."

The Board's analysis of this matter concludes that the Intermediary's reclassification is improper. The Board finds that the substantive documentary evidence presented in this case is the Provider's job description.[23] Moreover, this evidence shows that the Staff Development Coordinator function clearly provides benefit to all aspects of the Provider's patient care activities.

The Board notes that the Staff Development Coordinator is a Licensed Practical Nurse with acquired experience developing staff and providing training to adults. More specific to the issue, however, the Board notes the stated responsibilities of this position and their association to all aspects of patient care. For example, the Staff Development Coordinator manages the orientation of all new employees and is responsible for certain "Fundamental Duties/Essential Functions" such as: 1) participating in the development, implementation and evaluation of departmental goals, objectives, and policies, 2) serving as liaison to Department Heads and Supervisors to facilitate the identification of training needs, 3) contacting and scheduling appropriate personnel such as pharmacists, podiatrists, dentists and physicians to provide in-service training programs, and 4) evaluating and providing a course of action to improve the quality of care being provided to the residents by performing various other duties.

The Board, in reaching this decision, recognizes the importance for providers to maintain

[23] Exhibit I-10.

adequate records supporting claimed costs including employee time records when necessary. The Board did not, however, weigh heavily on the absence of time records in this particular issue for two reasons. First, as noted above, the Intermediary's adjustment appears almost entirely based upon the fact that the Staff Development Coordinator reports to the Director of Nursing rather than being based upon some other, more substantive matter such as time records. And secondly, under these circumstances, the Board finds the Provider's job description persuasive regarding the benefits provided by the Staff Development Coordinator to all provider operations. The Staff Development Coordinator function noticeably interacts with all other department heads and its work product (information) has a direct impact on all patient care activities and is generally essential to the operation of the entire facility.

Issue No. 2- Social Services

The Provider charged the costs of its Social Services function to its A&G Cost Center so they would be allocated to both routine and ancillary services 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 asserts that the Intermediary's reclassification is improper, and presents two fundamental arguments. First, the Provider argues that its classification is appropriate since Social Services provides benefits to patient care services as a whole, not just to the routine services portion, similar to the Staff Development Coordinator function discussed immediately above. Notwithstanding, the Provider asserts that a great deal of time spent by staff performing admissions related functions could be classified as Social Services and, as such, could be appropriately charged to the A&G Cost Center pursuant to program instructions.

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. Rather, the Board finds that Social Services equate far more towards a direct patient care activity than an A&G function. 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 Social Services costs associated with admissions related activities could be classified as A&G expenses. The Board notes that 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 Social Services costs dedicated to admissions related activities.

DECISION AND ORDER:

Issue No. 1 – Staff Development Coordinator Costs

The Intermediary's adjustment reclassifying the costs of the Provider's Staff Development Coordinator function from the A&G Cost Center to the Nursing Administration Cost Center is improper. The Intermediary's adjustment is reversed.

Issue No. 2- Social Services

The Intermediary's adjustment reclassifying the costs of the Provider's Social Services activities from the A&G Cost Center to the Social Services Cost Center and allocating those costs only to the routine services portion of the Provider's operation through Medicare's cost finding process is proper. The Intermediary's adjustment is affirmed.

Board Members Participating:

Suzanne Cochran, Esq.
Henry C. Wessman, Esq.
Stanley J. Sokolove
Dr. Gary Blodgett

DATE OF DECISION: December 20, 2002

FOR THE BOARD:

Suzanne Cochran, Esq.
Chairperson