# PROVIDER REIMBURSEMENT REVIEW BOARD
# HEARING DECISION

ON THE RECORD
2003-D25

**PROVIDER** –
Southwestern Nursing Home &
Rehabilitation Center
Pittsburgh, Pennsylvania

Provider No. 39-5742

**vs.**

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

**DATE OF HEARING –**
March 12, 2003

Cost Reporting Period Ended
December 31, 1997,
December 31, 1998

**CASE NOs.** 99-3866, 01-0764

**INDEX**

ISSUES:

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

2. Was the Intermediary's adjustment allocating social service costs proper?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Governing Statutes and Regulations:

The Medicare program was established in 1965 under Title XVIII of the Social Security Act (the Act) to provide health insurance to the aged and disabled. 42 U.S.C. §§ 1395 – 1395cc. The Health Care Financing Administration (HCFA) (now Center for Medicare and Medicaid Services (CMS)) is the operating component of the Department of Health and Human Services charged with administering the Medicare program.

In order to participate in the Medicare program, a hospital must file a provider agreement with the Secretary 42 U.S.C. § 1395cc. The Secretary's payment and audit functions under the Medicare program are contracted out to insurance companies known as fiscal intermediaries. Fiscal intermediaries determine payment amounts due the providers under the Medicare law and under interpretative guidelines published by CMS. Id.

At the close of its fiscal year, a provider must submit a cost report to the fiscal intermediary showing the costs it incurred during the fiscal year and which proportion of these costs are to be allocated to Medicare. 42 C.F.R. § 413.20. The fiscal intermediary audits the cost reports and determines the total amount of Medicare reimbursement due the provider, which it publishes in a notice of program reimbursement ("NPR") that sets forth the individual expenses allowed and disallowed by the intermediary. 42 C.F.R § 405.1803. A provider dissatisfied with the intermediary's final determination of total reimbursement may file an appeal with the Provider Reimbursement Review Board (Board) within 180 days of the NPR. 42 U.S.C. § 1395oo(a); 42 C.F.R. § 405.1835.

Background of the Provider:

Southwestern Nursing Home and Rehabilitation Center (Provider) is a 118-bed skilled nursing facility (SNF) located in Pittsburgh, Pennsylvania. On May 27, 1998, the Provider submitted its cost report for its fiscal year ended December 31, 1997. Veritus Medicare Services (Intermediary) performed a focus review of the Provider's cost report and issued a NPR on June 29, 1999. The NPR contained an adjustment pertaining to the classification of the Staff Development/Quality Assurance Coordinators' salaries as well as adjustments concerning the proper allocation of social service costs, based on the Intermediary's review of the Provider's cost reporting period ending December, 1997.

# PROVIDER REIMBURSEMENT REVIEW BOARD
# HEARING DECISION

ON THE RECORD
2003-D25

**PROVIDER** –
Southwestern Nursing Home &
Rehabilitation Center
Pittsburgh, Pennsylvania

Provider No. 39-5742

**vs.**

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

**DATE OF HEARING –**
March 12, 2003

Cost Reporting Period Ended
December 31, 1997,
December 31, 1998

**CASE NOs.** 99-3866, 01-0764

**INDEX**

Subsequently, the Intermediary audited the Provider's cost report for its fiscal year ended December 31, 1998, and issued an NPR on September 25, 2000.[1] Reflected in this NPR were adjustments concerning the proper allocation of social service cost.

The Provider was represented by Samuel L. Arena, CPA, of Gottlieb & Associates, P.C. The Intermediary's representative was Bernard M. Talbert, Esquire, of the Blue Cross and Blue Shield Association.

Issue No. 1- Staff Development/Quality Assurance Coordinator

Facts:

The Provider charged the salary expense of its Staff Development/Quality Assurance Coordinators to the Nursing Administration Cost Center per instruction from the Intermediary based on prior years audit adjustments. Since the Provider disagreed with the Intermediary's instruction, it reported the reimbursement effect of Staff Development / Quality Assurance Coordinators' salaries in the Nursing Administration Cost Center as a protested amount on its December 31, 1997, cost report.[2]

The effect of the Intermediary's adjustment results in a reduction to the Provider's program payments. Charging these expenses to the Administrative & General (A & G) Cost Center (Provider's preferred classification) allocates them to both routine and ancillary services which have a greater Medicare utilization and subsequent Medicare payment. The Intermediary charged them to Nursing Administration where they are allocated only to the routine area, thus reducing the Medicare payment.

PROVIDER'S CONTENTIONS:

The Provider asserts that charging the costs of its Staff Development/Quality Assurance Coordinators to the A&G Cost Center provides the most accurate and appropriate allocation of these expenses. The Provider explains that these individuals provide in-service to employees in all departments for all aspects of patient care in accordance with the job functions.

---

[1] See Intermediary's position paper at 4 (Case No. 01-0764).

[2] See Intermediary's position paper Exhibit I-1. The compensation for the Staff Development/Quality Assurance Coordinators was included in the total ($142,796) Nursing Administration salaries on the cost report.

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.[3] The Provider cites HCFA Pub. 15-1 § 2306[4], Cost Finding Methods, which 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[5], 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. 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. 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 costs to routine services would cause these costs to be borne by other patients in direct conflict with the Medicare regulations (42 C.F.R. § 413.5) and instructions.

The Provider contends that while A & G's accumulated costs statistic may not measure departmental use of all A & G costs with exact precision, the result accomplished using the A & G cost center is by far more accurate than the Intermediary's one hundred percent allocation to the routine areas. In support of its argument the Provider points to Extendicare 1996 Insurance Allocation Group v. Blue Cross and Blue Shield Association/United Government Services, PRRB Decision No. 2000-D88,[6] which states:

> [t]he Board finds that Medicare's cost finding process is designed to be fair and equitable to both the program and providers. It is not, however, designed to be a perfect process, meaning that every type of cost would be apportioned to Medicare with absolute precision… [and] recognizes that some A & G costs may be disproportionately allocated in favor of Medicare while others would be disproportionately allocated in favor of other payors.

The Provider contends that the record in this case clearly demonstrates that the duties and the functions of the Staff Development/Quality Assurance Coordinators relate to all aspects

---

[3] See Provider's Supplemental position paper at 2.

[4] See Provider's Supplemental position paper Exhibit P-12.

[5] See Provider's Supplemental position paper Exhibit P-13.

[6] Provider's Supplemental position paper Exhibit P-40.

of patient care and all departments of the facility, and therefore benefits the facility as a whole. The Provider argues that the documentation in the record supports the duties assigned in the employee's job description.[7]

In summary, the Provider asserts that the Intermediary has provided no clear and convincing evidence to rebut the Provider's position, other than making references to sections that have no applicability to this case. The Provider insists that the Intermediary's strict adherence to the conventional reporting methods resulted in a less appropriate and less accurate allocation of costs because the statistic utilized by the Intermediary excluded all non-routine cost centers which benefit from, and are served by, the Staff Development/Quality Assurance Coordinators.

INTERMEDIARY'S CONTENTIONS:

At the time of audit, the Intermediary determined that the Staff Development/Quality Assurance Coordinators' duties consisted of planning, conducting and scheduling of timely in-service training and maintaining an ongoing quality assurance program for the nursing service department. Since the residents of the facility were not charged for this service, the Intermediary considered the cost to be routine in nature and therefore appropriate to report these expenses in the Nursing Administration cost center to be allocated to the routine areas.

In its position paper, the Provider included a job description, training logs and attendee listings for support of the Staff Development/Quality Assurance Coordinator functions.[8] After examining these documents the Intermediary concluded that almost one hundred percent of the training was conducted for the nursing staff. Therefore, the Intermediary contends that the salaries associated with these positions were properly reported in the Nursing Administration cost center.

Issue No. 2 - Social Service

Facts:

The Provider filed its December 31, 1997 and 1998 cost reports using gross inpatient charges as the statistical basis for allocating social service costs. The Intermediary adjusted the statistical basis to patient days. The Intermediary determined this was a more accurate methodology since the adjustment would allow the social service costs to be allocated only to the routine areas it ultimately affected.

---

[7] See Provider's position paper Exhibit P-33.

[8] See Provider's position paper Exhibit P-33 and Intermediary's position paper Exhibit I-21.

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. 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.[9]

The Provider reported gross inpatient charges as its statistical basis for allocating social service costs for the cost reporting periods at issue. The Provider believed that gross inpatient charges provided the most accurate and appropriate allocation of social service costs as these personnel were responsible for various duties which relate to all aspects of patient care, including admitting, meetings with residents and their families, and discharge planning.

The Provider asserts that its position is further supported by a letter issued by the Acting Associate Regional Administrator, Division of Medicare, HCFA, on April 25, 1997.[10] 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." Id. 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. Therefore, the Provider asserts, it is clearly evident in the Medicare instructions and HCFA's April 25, 1997 letter that admitting costs are administrative in nature which should be allocated to all aspects of patient care, not only to routine areas.

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 A&G Department, one of which was admitting. The Provider asserts, therefore, this portion of the subject expenses clearly should be classified in the A&G Cost Center.

---

[9] See Provider's position paper at 31.

[10] See Provider's position paper at 32 and Exhibit P-22.

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 inpatient charges would also be an appropriate basis for allocating the subject costs pursuant to HCFA Pub. 15-1 § 2313.2(A). 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 inpatient charges would be appropriate.[11]

The Provider also contends that because its social service function benefits various aspects of its facility and patient care, allocating social service costs only to the routine service cost areas, as argued by the Intermediary, directly conflicts with Medicare's cross subsidization rule.[12] In general, the Provider contends that the limitations imposed by the Intermediary; i.e., allocating social service costs on the basis of patient days, results in a shifting of Medicare costs. The Intermediary's methodology incorrectly assumes that social services personnel spend no time whatsoever documenting ancillary services.[13]

Finally, in accordance with HCFA Pub. 15-1 § 2313, the Provider requested approval from Aetna (Provider's previous fiscal intermediary) to use "Gross Inpatient Charges" to allocate the Social Service and Medical Records cost centers in lieu of the recommended statistical basis on it's December 31, 1996 cost report.[14] Aetna did not respond to the Provider's request within the given time frame. Therefore, the Provider believed the changes were automatically accepted under Medicare instructions. In addition, the current Intermediary (Veritus Medicare Services) has previously allowed Social Services costs to be allocated based on gross inpatient charges on the Provider's December 31, 1996 audited cost report.[15]

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. 42 U.S.C. § x(v)(1)(A).

---

[11] See Provider's position paper at 31.

[12] See Provider's position paper at 34.

[13] See Provider's position paper at 35.

[14] See Provider's position paper at 36.

[15] See Provider's position paper at 36 and Exhibit P-27.

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that its adjustment allocating social service costs on the basis of patient days is proper. The Intermediary refers to HCFA Pub. 15-1 § 2203.1, which specifically discusses social service as a routine service cost.[16]

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. 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 centers. However, the Provider has offered no evidence to support a relationship of its Social Services department to the ancillary cost centers.

The Intermediary asserts that HCFA Pub. 15-2 § 1313 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 base shown at the top of each column on Worksheet B-1 is the recommended basis of allocation of the cost center indicated."[17] 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, any allocation based on patient days would most appropriately allocate the cost of this routine related service.

The Intermediary points out that this identical issue was addressed for this Provider in Southwestern Nursing Home and Rehabilitation Center v. Blue Cross and Blue Shield Association/Veritus Medical Services (Southwestern), PRRB Decision No. 2001-D28.[18] In that case the Board found that the social service function related to inpatient routine areas of the SNF and the patient days cost allocation statistic is therefore appropriate. The Board found that there was no evidence in the record demonstrating that social services, as a category of activity, benefits all aspects of patient care. The Board rejected the presumption that social service costs should be categorically allocated to both routine and ancillary areas.

---

[16] See Intermediary's position paper at 9 and Exhibit I-7.

[17] See Intermediary's position paper at 9 and Exhibit I-8.

[18] See Intermediary's position paper at 9 and Exhibit I-12.

The Intermediary requests that the Board affirm its determination to allocate social service costs on the basis of patient days in accordance with Southwestern.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board, after consideration of the Medicare law and Program instructions, parties' contentions and evidence presented, finds and concludes as follows:

Issue No. 1 – Nursing Administration

The Provider charged the salary expense of its Staff Development/Quality Assurance Coordinators to the Nursing Administration Cost Center per instruction from the Intermediary in relation to prior years audit adjustments. Since the Provider disagreed with the Intermediary's instruction, it reported the reimbursement effect of Staff Development / Quality Assurance Coordinators' salaries in the Nursing Administration Cost Center as a protested amount on the cost report. The Provider argues that classifying these costs in the Nursing Administration Cost Center results in a less accurate allocation of costs than classifying them as A&G expenses.

Specifically, the Provider asserts that the Staff Development/Quality Assurance Coordinators' 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 Staff Development/Quality Assurance Coordinators to the appropriate cost center for proper allocation purposes. 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. . . ."

The Board finds that in reviewing the Provider's in-service education logs and job descriptions the documentation does not support the Provider's position. Essentially, the logs show that the Staff Development/Quality Assurance Coordinator's functions and duties relate primarily to nursing activities.
The Provider refers to Christ the King Manor (Christ the King) v. Blue Cross and Blue

Shield Association / Veritus Medicare Services where the Board found that the job description showed that the Staff Development Coordinator function clearly provided benefit to all aspects of the Provider's patient care activities. The Board notes that this case is distinguishable from Christ the King in that the duties and functions of the personnel in question in Christ the King extended beyond nursing services.[19]

The Board concludes that the Provider has the burden of proving that the subject Staff Development/Quality Assurance Coordinators are responsible for all aspects of patient care, including ancillary services. In the instant case, the evidence presented does not adequately support the Provider's case.

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 interpretation of those instructions persuasive.

Finally, the Board rejects the Provider's argument that failure to allocate the costs of its Staff Development/Quality Assurance Coordinators to the ancillary cost centers shifts costs away from the Medicare program in violation of the Cross-Subsidization Rule. 42 U.S.C. § x(v)(1)(A). This argument is contingent upon a finding that the Staff Development/Quality Assurance Coordinators are responsible for all aspects of patient care, which has not been proven.

Issue No. 2 - Social Services

The Provider reported gross inpatient charges as its statistical basis for allocating social service costs to both routine and ancillary cost centers through Medicare's cost finding process. The Provider believed that gross inpatient charges provided the most accurate and appropriate allocation of social service costs as these personnel were responsible for various duties which relate to all aspects of patient care, including admitting, meetings with residents and their families and discharge planning. The Intermediary, however, adjusted the statistical basis to patient days, which it felt was a more accurate methodology since the result of the adjustment would allow the social service costs to be allocated only to the routine areas ultimately affected.

[19] PRRB Decision No. 2003-D10, Christ the King was reversed by the CMS Administrator because the job description was not contemporaneous. However, the Board notes that the Intermediary relied on the job description in that case.

The Provider asserts that the Intermediary's decision to allocate social service costs using patient days as the statistical basis is improper and presents two fundamental arguments. First, the Provider argues that its use of gross inpatient charges as a statistical basis to allocate social service costs was 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. Second, the Provider asserts that a great deal of time spent by staff performing admissions related functions could be classified as A & G and, as such, could be appropriately charged to the A&G Cost Center for purposes of allocating those costs using the basis of accumulated costs 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 more closely to a direct patient care activity than an administrative 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 finds that the Provider must be able to distinguish or split out the admitting portion of its social services expenses in order to classify them as administrative and general in nature. 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.

Finally, the Provider argues it was granted tacit approval from the Intermediary since it had requested the use of "Gross Inpatient Charges" to allocate social service costs in lieu of the recommended statistical basis for it's previous cost reporting period and the Intermediary did not respond to the Provider's request within the given time frame. Therefore, the Provider believed the changes were automatically accepted under HCFA Pub. 15-1 § 2313.

The Board notes that the Intermediary does not dispute that the Provider had tacit approval. However, the Provider is required to prove that the change in statistical basis resulted in a more appropriate and more accurate allocation of cost and is supported by **adequate auditable documentation** in accordance with HCFA Pub. 15-1 § 2313. Under the principles of cost reimbursement, providers are required to maintain and furnish sufficient financial records and statistical data to the intermediary for proper determination of costs payable under the program in accordance with 42 C.F.R. § 413.20.

In this case, the Board finds that although the Provider was granted tacit approval, it did not meet the necessary requirements of the Medicare regulations and instructions in

furnishing sufficient financial records, statistical data and adequate auditable documentation to support the allocation requested. Therefore, due to lack of Provider evidence, the Board concludes that the Intermediary's determination was appropriate.

DECISION AND ORDER:

Issue No. 1 – Nursing Administration

The Intermediary's adjustment to the Staff Development/Quality Assurance Coordinators' salaries are proper. The Intermediary's adjustment is affirmed.

Issue No. 2 - Social Services

The Intermediary's adjustment allocating social service costs on the basis of patient days only to the routine services portion of the Provider's operation through the cost finding process is proper. The Intermediary's adjustment is affirmed.

BOARD MEMBERS PARTICIPATING:

Suzanne Cochran, Esquire
Henry C. Wessman, Esquire
Dr. Gary Blodgett
Martin W. Hoover, Jr., Esquire

Date of Decision: May 1, 2003

FOR THE BOARD

Suzanne Cochran, Esquire
Chairman