

CMS Publication 15-1 – Provider Reimbursement Manual

Section 600- Grants, Gifts, and Income from Endowments

Section 2104 – Unallowable Costs Related to Patient Care

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Section 2136 – Advertising Costs

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**CMS Program Manuals - Provider Reimbursement (PUB. 15)  
Provider Reimbursement Manual Part I  
Manual  
Chapter 6 - Grants, Gifts, and Income From Endowments  
600. Principle**

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*INTRODUCTION--Providers must follow the Medicare principles of reasonable cost reimbursement, including the provisions of this chapter and other chapters in this manual, when completing the Medicare cost report. Home offices must also follow these principles when completing a home office cost statement.*

**600. Principle**

For cost reporting periods beginning on or after October 1, 1983, grants, gifts, and income from endowments, whether or not the donor restricts the use for a specific purpose, are not deducted from a provider's operating costs in computing reimbursable cost. For periods beginning prior to October 1, 1983, restricted grants, gifts, or endowment income designated by a donor for paying specific operating costs were deducted from the particular operating cost or group of costs.

<b>Section Revision History</b>
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600. Principle (Prior to Rev. 455; Effective: N/A; Issued: 12/14/12)
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**CMS Program Manuals - Provider Reimbursement (PUB. 15)  
Provider Reimbursement Manual Part I  
Manual  
Chapter 21 - Cost Related to Patient Care  
2104. Unallowable Costs Related to Patient Care**

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**2104. Unallowable Costs Related to Patient Care**

**2104.1 Ambulance Service.**--Ambulance service is covered under Part B of the Medicare program. A provider may furnish ambulance service directly or it may furnish the service under arrangements with a supplier of ambulance services. The cost the provider incurs to furnish ambulance service is paid by Medicare on a reasonable cost basis.

If a provider furnishes ambulance services with its own equipment and staff, the cost it incurs (depreciable cost of equipment, supplies, employee compensation, overhead, etc.) is its cost of the service for Medicare payment purposes. If it furnishes the service under arrangements, the charge to the provider by the ambulance company becomes the provider's direct cost of furnishing the service.

Medicare Part B carriers have established reasonable charge screens for a wide range of ambulance services furnished by suppliers of ambulance services for which claims are billed to the carriers. Medicare expects that the costs incurred by a provider for ambulance services furnished under arrangement with a supplier of ambulance services will not exceed the amount a carrier would pay the ambulance supplier for the same service. Therefore, if a provider furnishes ambulance service under arrangements, to the extent the provider's total costs of the services, direct costs and any indirect costs, exceeds what a carrier would pay a supplier of ambulance services for the same services in the same locality, the costs are unreasonable and cannot be paid by the provider's intermediary.

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**2104.2 Private-Duty Personnel.**-- The costs of private-duty nurses and other private-duty attendants are not included in allowable costs. Services of private nurses and attendants are specifically excluded from coverage by law.

**2104.3 Luxury Items or Services.**--

A. General.-- Where provider operating costs include amounts that flow from the provision of luxury items or services, such amounts are not allowable in computing reimbursable costs.

B. Definitions.-- Luxury items or services are those that are substantially in excess of or more expensive than the usual items or services rendered within a provider's operation to the majority of patients. This provision should not be confused with the other provision dealing with limitations on coverage of costs as referenced in E below. Examples of luxury items or services are given below.

1. Luxury Room Accommodations.-- Some indications which tend to support a conclusion of the existence of luxury room accommodations are (a) the room size per bed is significantly larger than the usual room size per bed in the provider's operation and (b) the room charges are higher than the rates charged by the provider for its usual rooms. Other indications which may distinguish the luxury rooms from the usual rooms are the presence of refrigerators, special beds, and lavish bathing accommodations.

2. **Luxury Food Items.**-- Indications that would support a conclusion that certain food costs represent luxury items are (a) the provider maintains a separate kitchen for the preparation of special foods and (b) selected patients may order from a separate menu. Special diets ordered by a patient's physician or that permit a patient to continue with his already established dietary habits required for good cause are not considered luxury food items.

C. **Application.**-- Once it has been determined that luxury items or services have been furnished, allowable costs must be reduced by the difference between the costs of luxury items or services actually furnished and the reasonable costs of the usual less expensive items or services furnished by a provider to the majority of its patients. Where patients request luxury items or services, the provider may charge the patients for the excess costs involved.

(See § 2106.1 for the proper handling of the full costs of items or services such as telephone, television, and radio which are furnished solely for the personal comfort of the patients.)

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#### 2104.4 COSTS RELATED to PATIENT CARE 1-76

EXAMPLE:

##### **Facts**

A 300-bed hospital provides 50 private luxury room accommodations which are twice the size per bed as the size per bed of the remaining private accommodations. In addition, the luxury rooms are equipped with special beds, balconies, ceiling-to-floor length picture windows, color television sets, stereo equipment, and lavish baths. The hospital also offers special food service to patients occupying the luxury rooms.

##### **Determination of Allowable Costs**

Where a determination has been made that a provider furnishes luxury items or services, a single nonreimbursable cost center entitled "Luxury Routine Accommodations" must be established and the excess direct and indirect cost luxury items should be determined and eliminated through cost finding. However, where the intermediary determines that overhead costs applicable to the excess costs of luxury routine accommodations would be minimal, the adjustment to eliminate the excess costs need not be accomplished through cost finding. Also, the total costs of such items as the color television and stereo would be eliminated from allowable costs since they are for the sole personal comfort of the patients (§ 2106.1).

D. **Effect on Medicare Program Charges.**-- For the purpose of establishing proper interim reimbursement, program charges should not reflect the excess costs applicable to luxury routine accommodations. Rather, the portion of charges applicable to these excess costs should be billed as noncovered charges.

E. **Effect on Other Provisions of Law.**-- (1972 Amendments - Public Law 92-603, Section 223 and 233.) Where a provider furnishes luxury items or services to all patients in the facility, the provisions of this section do not apply. Rather, the provision dealing with limitations on coverage of costs (section 223) must be applied to such a provider. Also, for purposes of applying the limitation of program reimbursement to the lower of reasonable costs or customary charges (section 223), reasonable costs do not include the excess costs of luxury items or services and customary charges do not include the portion of the charges applicable to the excess costs of luxury items or services.

**2104.4 Dental Services.**-- Compensation paid to a dentist for services to or for an individual patient are not allowable provider costs and are nonreimbursable to the provider. The costs, however, of consultative services furnished by an advisory dentist to a provider are allowable costs, subject to the usual rules concerning reasonable costs incurred

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by providers. Consultative services may include, for example, participating in the staff development program for nursing and other personnel and recommending policies relating to oral hygiene or dietary matters. For a detailed explanation of the coverage of inpatient services in connection with dental procedures, see §210.7 of the Hospital Manual (HCFA Pub. 10).

**2104.5 Vocational and Scholastic Training Expense.**-- The costs attributable to vocational, scholastic, or similarly oriented training activities conducted by providers on behalf of patients are not allowable costs. For example, costs incurred by a psychiatric facility in operating an elementary or secondary school for patients are unallowable costs.

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**Chapter 21 - Cost Related to Patient Care**

**2105. Unallowable Costs not Related to Patient Care**

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**2105. Unallowable Costs not Related to Patient Care**

**2105.1 Noncompetition Agreement Costs.**--Amounts paid to the seller of an ongoing facility by the purchaser to acquire an agreement not to compete are considered capital expenditures. Where the agreement covers a stated number of years and the provider amortizes the amount paid over the agreed number of years, the amortized costs for such agreements are not allowable costs under the program.

**2105.2 Cost of Meals for Other Than Provider Personnel.**--The cost of meals for other than provider personnel, whether served in a cafeteria, coffee shop, canteen, etc., is unallowable under the program because it is not related to patient care. (See §2102.3) Providers must maintain adequate cost data in order to determine the cost of these meals. (See §2300ff.)

**2105.3 Cost of Reserving Beds or Services.**--

A. Provider Making Payment to Reserve Beds or Services.--Providers may incur costs pursuant to a reserved bed agreement with another health care facility under which the provider receives guaranteed or priority placement for its discharged patients. For example, a hospital may pay a skilled nursing facility (SNF) to set aside a certain number of beds for the hospital's discharged patients. The cost incurred by a provider under a reserved bed agreement is not related to that provider's care of its patients and, therefore, is not an allowable cost.

B. Provider Receiving Payment for Reserving Beds or Services.--The revenue received by a provider for reserving its beds or services is not considered related to patient care. Therefore, the payments received are not required to be offset against the provider's operating costs.

C. Payment-In-Kind for Reserving Beds or Services.--If, under the terms of the agreement, a provider agrees to compensate another facility for reserving its beds by providing free or discounted services rather than by cash payments, neither the provider furnishing the services nor the provider receiving the services as payment-in-kind, is entitled to be reimbursed by Medicare for the cost of the services. (See §2328 F.)

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**ANCHORYESNO 2105.3(Cont.) COSTS RELATED to PATIENT CARE 03-85**

D. Types of Agreements and Illustrations.--Providers are permitted to enter into reserved bed agreements, as long as the terms of that agreement do not violate the provisions of the statute and regulations which govern provider agreements which (1) prohibit a provider from charging the beneficiary or other party for covered services; (2) prohibit a provider from discriminating against Medicare beneficiaries, as a class, in admission policies; or (3) prohibit certain types of payments in connection with referring patients for covered services. A provider may jeopardize its provider agreement or incur other penalties if it enters into a reserved bed agreement that violates these requirements.

The following examples illustrate different types of reserved bed agreements and explain how each would be treated in terms of the provider agreement and reimbursement.

Illustration 1

A SNF reserves 10 beds for the exclusive use of a hospital's discharged patients. The hospital agrees to pay \$75.00 per day per bed for each day a reserved bed is held vacant.

This agreement does not violate the SNF's provider agreement. The hospital cannot include the cost it incurs to reserve the SNF beds in its allowable costs. The SNF does not reduce its allowable costs by the payment received from the hospital in determining program reimbursement.

#### Illustration 2

A SNF reserves 10 beds for the exclusive use of a hospital's discharged patients. The hospital agrees to pay \$75.00 per day per bed for each day a reserved bed is held vacant. The hospital further agrees to pay the difference between \$75.00 and the Medicare reimbursement rate of \$60.00 to the SNF for each day a reserved bed is occupied by one of the hospital's discharged Medicare patients.

This agreement violates the SNF's provider agreement. The additional payment of \$15.00 per day paid by the hospital is a prohibited charge imposed by the SNF on another party for services that are covered by Medicare.

#### Illustration 3

A SNF agrees to reserve 10 beds for the exclusive use of a hospital's discharges. The hospital agrees to provide the SNF, without charge, a full-time registered nurse.

The agreement does not violate the SNF's provider agreement since the full-time nurse is provided for all patients and without regard to whether a Medicare patient is receiving services from the SNF. The hospital's reimbursement would not be affected except that any costs incurred by the hospital in providing the nurse should be adjusted out of the hospital's allowable costs for purposes of determining reimbursement for any services which are reimbursed on a reasonable cost basis. (See §2328F.) The adjustment is necessary because the nursing cost is not related to patient care of hospital patients. On

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the other hand, the value of the nursing service received by the SNF is not considered revenue that is offset against its allowable costs in determining reimbursement. Similarly, the SNF may not impute the cost of the nursing services received for inclusion in its costs.

#### Illustration 4

A SNF agrees to reserve 10 beds for the exclusive use of a hospital's discharges. There is no charge for holding the beds vacant, although the hospital agrees to provide the SNF, without charge, a registered nurse for each of the three shifts whenever any of the reserved beds are occupied by a Medicare covered patient.

This agreement violates the SNF's provider agreement because the nursing services are provided only when a Medicare patient is in a reserved bed and, therefore, the services of the nurse are considered to be a payment-in-kind for providing services covered under Medicare.

#### Illustration 5

A SNF agrees to hold at least 5 beds on a priority basis for a hospital's discharges. The hospital agrees to provide, under arrangements, pharmacy, laboratory and radiology services for all of the SNF's patients. The agreement specifies no charge for laboratory and radiology services and provides a 30 percent discount for pharmacy.

The agreement does not violate the provider agreement of the SNF since free or discounted services are provided to all patients and without regard to whether a Medicare patient is

receiving services from the SNF. The cost of providing free or discounted services is not an allowable cost for purposes of determining hospital reimbursement. Therefore, to assure that Medicare hospital patients do not share in the cost of the free or discounted services, the charges of the ancillary service centers are to be grossed-up to reflect the services provided to SNF patients. (See §2314.B.) There is no effect on the reimbursement of the SNF as a result of the free or discounted services furnished by the hospital. That is, the SNF may not impute any costs for the free services for inclusion in its cost report; it may only include the discounted charges (if reasonable) in its allowable costs for the discounted services.

#### Illustration 6

A SNF agrees to accept a hospital's "complicated care" patients on a priority basis. In return, the hospital agrees to provide free in-service education to the SNF's staff.

This agreement does not violate the SNF's provider agreement. The hospital's reimbursement is not affected except that any costs incurred by the hospital for providing the in-service training is adjusted out of the hospital's allowable costs for purposes of determining reimbursement for any services which are reimbursed on a reasonable cost basis. (See §2328.F.) The adjustment is necessary because the training cost is not related to patient care of hospital patients. On the other hand, the value of in-service training received by the SNF is not considered revenue that is offset against its allowable costs in determining reimbursement. Similarly, the SNF may not impute the cost of training received for inclusion in its costs.

**2105.4 Costs of Unsuccessful Beneficiary Appeals.**--Costs incurred by providers of services on or after October 21, 1986, representing beneficiaries in unsuccessful appeals are not allowable costs. Conversely, costs incurred by providers of services representing beneficiaries in successful appeals are allowable to the extent they are otherwise reasonable.

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#### 2105.5 COSTS RELATED to PATIENT CARE 06-98

**2105.5 Costs of Management Employee Meals.**--Costs incurred by providers for meals served to executives or management employees in excess of the costs of meals served to ordinary employees are not allowable costs. Excessive costs of executive or management employees' meals are attributable to the use of separate dining facilities, duplicative or additional food service staff, and/or upgraded or gourmet menus. Conversely, the unrecovered costs related to meals served to executives or management employees from common menus in common employee dining facilities are allowable to the extent that they are otherwise reasonable.

**2105.6 Costs of Employee Travel.**--Costs incurred by providers in conjunction with employee travel are generally allowable to the extent that they are patient care related and reasonable. However, travel costs incurred in conjunction with non-patient care related employee travel are not allowable. Foreign travel costs are allowable only where the provider can clearly substantiate the reasonableness and patient care relatedness of the travel costs to the satisfaction of the Medicare fiscal intermediary.

**2105.7 Costs of Gifts or Donations.**--Costs incurred by providers for gifts or donations to charitable, civic, educational, medical or political entities are not allowable.

**2105.8 Costs of Entertainment.**--Costs incurred by providers for entertainment, including tickets to sporting or other events, alcoholic beverages, golf outings, ski trips, cruises, professional musicians or other entertainers, are not allowable. Costs incurred by providers for purposes of employee morale, specifically, for an annual employee picnic, an annual Christmas or holiday party, an annual employee award ceremony or for sponsorship of employee athletic programs (bowling, softball, basketball teams, etc.), are allowable to the extent that they are reasonable.



**2105.9 Costs of Employees' Personal Use of Motor Vehicles.**--Costs incurred by providers related to the personal use of provider vehicles are not allowable.

**2105.10 Costs of Fines or Penalties.**--Costs incurred by providers for fines or monetary penalties imposed for violations of Federal, State, or local laws are not allowable.

**2105.11 Costs of Spousal or Dependents Education.**--Costs incurred by providers related to the education of spouses or other dependents of owners or officers of providers of services, provider employees and provider contractors are not allowable when they are not active employees of the provider or contractor.

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2136. Advertising Costs--General**

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**2136. Advertising Costs--General**

The allowability of advertising costs depends on whether they are appropriate and helpful in developing, maintaining, and furnishing covered services to Medicare beneficiaries by providers of services. In determining the allowability of these costs, the intermediary should consider the facts and circumstances of each provider situation as well as the amounts which would ordinarily be paid for comparable services by comparable institutions. To be allowable, such costs must be common and accepted occurrences in the field of the provider's activity.

**2136.1 Allowable Advertising Costs.**--Advertising costs incurred in connection with the provider's public relations activities are allowable if the advertising is primarily concerned with the presentation of a good public image and directly or indirectly related to patient care. Examples are: visiting hours information, conduct of management-employee relations, etc. Costs connected with fund-raising are not included in this category (see § 2136.2).

Costs of advertising for the purpose of recruiting medical, paramedical, administrative and clerical personnel are allowable if the personnel would be involved in patient care activities or in the development and maintenance of the facility.

Costs of advertising for procurement of items or services related to patient care, and for sale or disposition of surplus or scrap material are treated as adjustments of the purchase or selling price.

Costs of advertising incurred in connection with obtaining bids for construction or renovation of the provider's facilities should be included in the capitalized cost of the asset (see Chapter I, § 104.10).

Costs of advertising incurred in connection with bond issues for which the proceeds are designated for purposes related to patient care, i.e., construction of new facilities or improvements to existing facilities, should be included in "bond expenses" and prorated over the life of the bonds.

Costs of activities involving professional contacts with physicians, hospitals, public health agencies, nurses' associations, State and county medical societies, and similar groups and institutions, to apprise them of the availability of the provider's covered services are allowable. Such contacts make known what facilities are available to persons who require such information in providing for patient care, and serve other purposes related to patient care, e.g., exchange of medical information on patients in the provider's facility, administrative and medical policy, utilization review, etc. Similarly, reasonable production and distribution costs of informational materials to professional groups and associations, such as those listed above, are allowable if the materials primarily refer to the provider's operations or contain data on the number and types of patients served. Such materials should contribute to an understanding of the role and function of the facility as a provider of covered health care in the community.

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**2136.1 (CONT) COSTS RELATED to PATIENT CARE 09-82**

Costs of informational listings of providers in a telephone directory, including the "yellow pages," or in a directory of similar facilities in a given area are allowable if the listings are consistent with practices that are common and accepted in the industry.

Costs of advertising for any purpose not specified above or not excluded below may be allowable if they are related to patient care and are reasonable.

**2136.2 Unallowable Advertising Costs.--**

Costs of fund-raising, including advertising, promotional, or publicity costs incurred for such a purpose, are not allowable.

Costs of advertising of a general nature designed to invite physicians to utilize a provider's facilities in their capacity as independent practitioners are not allowable. See section 2136.1 for allowability of professional contact costs and costs of advertising for the purpose of recruiting physicians as members of the provider's salaried staff.

Costs of advertising incurred in connection with the issuance of a provider's own stock, or the sale of stock held by the provider in another corporation, are considered as reductions in the proceeds from the sale and, therefore, are not allowable.

Costs of advertising to the general public which seeks to increase patient utilization of the provider's facilities are not allowable. Situations may occur where advertising which appears to be in the nature of the provider's public relations activity is, in fact, an effort to attract more patients. An analysis by the intermediary of the advertising copy and its distribution may then be necessary to determine the specific objective. While it is the policy of the Health Care Financing Administration and other Federal agencies to promote the growth and expansion of needed provider facilities, general advertising to promote an increase in the patient utilization of services is not properly related to the care of patients.

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Manual**

**Chapter 21 - Cost Related to Patient Care  
2138. Membership Costs--General**

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**2138. Membership Costs--General**

Providers customarily maintain memberships in a variety of organizations and consider the costs incurred as a result of these memberships to be ordinary provider operating costs.

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Some of those organizations promote objectives in the provider's field of health care activities. Others have purposes or functions which bear little or no relationship to this activity. In order to determine for Medicare purposes the allowability of costs incurred as a result of membership in various organizations, memberships have been categorized into three basic groups:

1. professional, technical or business related;
2. civic; and
3. social, fraternal, and other.

**2138.1 Professional, Technical, or Business Related Organizations.**--The Medicare program classifies organizations in this category if their functions and purposes can be reasonably related to the development and operation of patient care facilities and programs, or the rendering of patient care services. Memberships in these organizations, while not restricted to providers, are generally comprised of provider, provider personnel, or others who are involved or interested in patient care activities.

Costs of memberships in such organizations are allowable for purposes of program reimbursement. These costs include initiation fees, dues, special assessments, and subscriptions to professional, technical or business related periodicals. (See §2139.3 regarding lobbying activities.) Also included are costs related to meetings and conferences, such as meals, transportation, registration fees and other costs incidental to those functions, when the primary purpose of such meetings and conferences is the dissemination of information for the advancement of patient care or efficient operation of the facility.

**2138.2 Civic Organizations.**--These organizations function for the purpose of implementing civic objectives. Reasonable costs of initiation fees, dues, special assessments, and subscriptions to periodicals of civic organizations are allowable. (See §2139.3 regarding lobbying activities.) Also allowable are those reasonable costs related to meetings and conferences, such as meals, transportation, registration fees, and other costs incidental to these functions when the primary purpose of such meetings and conferences is the promotion of civic objectives.

**2138.3 Social, Fraternal, and Other Organizations.**--Generally, these organizations concern themselves with activities unrelated to their members' professional or business activities. Their objectives and functions cannot be considered reasonably related to the care of beneficiaries. Consequently, provider costs incurred in connection with memberships in social, fraternal, and other organizations are not allowable.

**2138.4 Reasonableness of Provider's Participation in Approved Membership Activities.**--The program looks to comparable providers, as well as to the justification by the

individual provider, in determining the reasonableness of the number of organizations in which the provider maintains memberships and the claimed costs of such memberships.

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**Chapter 21 - Cost Related to Patient Care**

**2139. Political and Lobbying Activities (Updated through Rev. 436; Issued: 03/28/08; Effective: 03/28/08)**

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**2139. Political and Lobbying Activities (Updated through Rev. 436; Issued: 03/28/08; Effective: 03/28/08)**

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Provider political and lobbying activities are not related to the care of patients. Therefore, costs incurred for such activities are unallowable.

**2139.1 Provider Political Activities.**--Costs of political activities are unallowable. These activities include, but are not limited to, provider involvement with political parties, candidates/incumbents of political parties, and political action committees or similar committees or associations. Likewise, contributions made directly to political parties or candidates or contributions made indirectly, e.g., through other individuals, committees, or associations, are unallowable. (See §2139.3 regarding dues to trade or other organizations related to such organizations' lobbying or political activities.)

**2139.2 Provider Lobbying Activities.**--

A. Lobbying Activities.--Lobbying is any activity whereby a directed effort is made to influence legislation. Costs of lobbying activities are unallowable. The policy applies whether the lobbying involves Medicare activities or activities unrelated to Medicare and whether the provider lobbies with its own employees or engages others, directly or indirectly, to lobby on its behalf.

Government agencies other than HCFA have developed specific policies regarding lobbying. While other agencies may apply their policies and procedures differently or use different nomenclature than HCFA, e.g., in the case of the Internal Revenue Service (IRS), by means of nondeductible business expenses rather than unallowable costs, the general intent behind policies of those agencies and of HCFA is the same. Costs of lobbying are costs in which the government does not participate. HCFA does not intend providers to be subject to varying rules on lobbying costs among government agencies, resulting in nonuniform treatment of the costs and additional provider recordkeeping. Therefore, if a non-HCFA agency, e.g., the IRS, has developed policies and procedures defining lobbying activities and addressing the costs, HCFA does not expect providers to follow different rules in determining Medicare payment. Rather, providers subject to rules of non-HCFA agencies on lobbying can follow those rules in determining payment under Medicare to the extent such rules are in accordance with Medicare policy which disallows any costs of lobbying activities.

B. Activities Which Are Not Lobbying.--Contacts by a provider with HCFA or other government agencies with which it has business dealings is not lobbying unless the contacts are determined to be directed toward influencing legislation. For example, if a provider, group of providers, or provider trade organization comments on a HCFA proposal, that activity is not lobbying. Or, if a provider disputes a point of Medicare policy or its application or has a suggestion regarding policy, contact with HCFA or an intermediary by the provider or an organization to discuss such issues is not lobbying.

**2139.3 Organization Dues Related to Lobbying and Political Activities.**--Trade or other organizations and associations often engage in lobbying and political activities as part of their activities. Therefore, in accordance with the policy in §§2139.1 and 2139.2, the portion of an

organization's dues or other payments related to these activities, including special assessments, is an unallowable cost.

21-24.2 Rev. 387

#### 03-08 COSTS RELATED to PATIENT CARE 2140.2

For cost reporting periods beginning on or after January 1, 1996, this policy requires identification and disallowance of the portion of dues related to lobbying and political activities. For prior periods, the policy does not require identification but requires disallowance of any identified portion.

The policy in §2139.2 permitting providers to follow the rules of other government agencies on lobbying activities in determining unallowable lobbying costs under Medicare applies also to dues. In particular, for Federal income tax purposes, §13222 of the Omnibus Budget Reconciliation Act of 1993 generally requires tax-exempt organizations to report to their members the nondeductible portion of dues related to an organization's lobbying and political activities. The reporting required under that provision satisfies Medicare's requirement for identification of the portion of an organization's dues related to lobbying and political activities. If an organization is not required to report to its members for tax purposes, for Medicare purposes, the portion of dues for lobbying and political activities remains unallowable as if the organization were required to report. In such cases, a provider will need to request the information from the organization in order to report for Medicare purposes only the portion not related to lobbying and political activities.

In light of policy by *CMS* and other agencies requiring identification of the lobbying and political activities portion of an organization's dues, *CMS* believes it unlikely a provider will be unable to, or choose not to, identify such portion. However, if a portion is not identified for Medicare payment purposes and the intermediary is aware of the organization's ongoing lobbying or political activities, all costs associated with the provider's dues to the organization are unallowable unless the provider can document the unallowable portion for lobbying and political activities.

This policy is not limited to dues incurred by a provider on its own behalf. It applies also to dues a provider pays, as a business or fringe benefit expense, on behalf of its employees and officers in professional, trade, or other organizations to which they belong, e.g., associations of nurses, therapists, administrators, or accountants. Only the portion of the dues not related to lobbying or political activities of the organizations is an allowable cost.

<b>Section Revision History</b>
2139. Political and Lobbying Activities (Prior to Rev. 436; Effective: 03/28/08; Issued: 03/28/08)

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Chapter 23 - Adequate Cost Data and Cost Finding  
2307. Direct Assignment of General Service Costs**

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**2307. Direct Assignment of General Service Costs**

The costs of a general service cost center need to be allocated to the cost centers receiving service from that cost center. This allocation process is usually made, for Medicare cost reporting purposes, through cost finding using a statistical basis that measures the benefit received by each cost center. Alternatives to cost finding as described below may be used where appropriate after obtaining intermediary approval. The provider must make a written request to its intermediary and submit reasonable justification for approval of the change no later than 90 days prior to the beginning of the cost reporting period for which the change is to apply. The intermediary must respond in writing to the provider's request, whether approving or denying the request, prior to the beginning of the cost reporting period to which the change is to apply.

When the request is approved, the change must be applied to the cost reporting period for which the request was made, and to all subsequent cost reporting periods unless the intermediary approves a subsequent request for a change by the provider. The effective date of the change will be the beginning of the cost reporting period for which the request has been made.

A. Direct Assignment of Cost.--Direct assignment of cost is the process of assigning directly allocable costs of a general service cost center (see §2302.9) to all cost centers receiving service from that cost center based upon actual auditable usage. Hours worked by hourly wage or metered utility consumption are examples of measures of actual usage. Estimates, including a statistical surrogate such as square feet, are not acceptable. Time studies are considered statistical surrogates and, thus, may not be used as a basis for direct assignment of costs. Indirectly allocable supervision costs, other indirectly allocable costs (hereinafter, residual costs) and costs allocated from previously allocated general service cost centers (hereinafter, overhead costs) must not be directly assigned to the using cost centers, but must be allocated through cost finding.

23-8 Rev. 336

08-86 ADEQUATE COST DATA and COST FINDING 2307 (Cont.)

Note: This subsection describes direct assignment of general service costs on the provider's accounting records and is distinguished from the allocation of direct salary and wage costs as described in §2313.2E.

The direct assignment of costs must be made as part of the provider's accounting system with costs recorded in the ongoing normal accounting process. This means costs are to be recorded on a regular basis throughout the accounting period, not only as period ending adjusting entries. For example, if the costs being directly assigned are an element of payroll costs, the direct assignment should be recorded as often as all payroll costs are recorded (usually each pay period). If a provider fails to maintain the records as specified in its request and as a basis for the intermediary's approval, no direct assignment of cost is allowed for the cost reporting period and a new request must be initiated for any future direct assignment of cost.

Examples of acceptable direct assignment of cost to benefitting cost centers are salaries paid to housekeeping staff directly assigned, based on time records of housekeeping maintained throughout the cost reporting period; purchased laundry and linen costs directly assigned,



based on invoices which identify the cost for each benefitting cost center; and depreciation on movable equipment physically present or used in each of the cost centers.

The following conditions must be met before Medicare will accept direct assignment for cost reporting purposes:

1. All costs within the general service cost center which can be directly allocated must be assigned to the benefitting cost centers as part of the provider's routine accounting process.
2. Any indirect supervision and residual costs remaining in the cost center together with any previously allocated overhead must be allocated through cost finding to all remaining benefitting cost centers.
3. The basis for assigning directly allocable costs of a general service cost center to the benefitting cost centers must be on a factual and auditable basis. This precludes the use of averages, estimates or statistical surrogates such as square feet. For example, the assignment of actual housekeeping salaries by each employee based on actual hours worked in the benefitting cost centers is acceptable, whereas the use of the surrogate, square feet, is inappropriate for direct assignment.
4. The basis of allocation for cost finding any indirect supervisory costs, residual costs and allocated overhead must be an appropriate measure of the benefits provided to the remaining cost centers. Any deviation from the allocation basis prescribed for cost finding must be reviewed and approved by the intermediary in advance as part of the provider's request for direct assignment of costs.

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#### 2307 (Cont.) ADEQUATE COST DATA and COST FINDING 08-86

**B. Direct Assignment of Costs to Provider Components.**--In some cases, providers may only be able to directly assign costs of a general service cost center by subdividing existing cost centers and, in turn, allocating costs via cost finding for the benefitting cost centers within each of the specific general service cost centers.

For example, a provider may have two buildings of differing ages and depreciation related to each can be factually ascertained. Each building would become a general service cost center and the allocation to the cost centers within each would be separately accomplished using an appropriate statistical basis such as square feet. Another example could be the separate metering of utilities for each building within a health care complex: separate general service cost centers for each building would be established and utility cost would be directly assigned to the using building based on actual bills incurred during the reporting period. Statistical allocations to benefitting cost centers within each building would be required.

To accommodate additional general service cost centers, the provider must add additional columns to the allocation worksheets, or attach a supporting worksheet with similar information, to document the step-down of costs to those cost centers benefitting from the general service cost centers. Any modifications necessary to worksheets after the cost allocation must also be approved by the intermediary as part of the request for direct assignment of costs.

For determining nonallowable costs applicable to the nonpaid workers cost center, the analysis set forth at §707.2 would still be required.

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#### 08-86 ADEQUATE COST DATA and COST FINDING 2307 (Cont.)

Example of Component Allocation: Building Depreciation

There are two buildings housing the hospital and the SNF, built in 1950 and 1975, respectively. Annual depreciation is \$100,000 for the hospital and \$50,000 for the SNF. (The cost centers are not all-inclusive and are shown to illustrate the principle.)

	Hospital		SNF	
	<u>Statistic</u> (Sq. Feet)	<u>Cost</u>	<u>Statistic</u> (Sq. Feet)	<u>Cost</u>
Admin. & Gen.	25,000	10,000		
Operation of Plant	75,000	30,000		
Dietary	10,000	4,000		
Radiology	20,000	8,000		
Laboratory	12,500	5,000		
Adult & Ped.	100,000	40,000		
Special Care	7,000	2,800		
SNF-Certified*			70,000	35,000
SNF-Noncertified*			30,000	15,000
Gift Shop	<u>500</u>	<u>200</u>		
	<u>250,000</u>	<u>100,000</u>	<u>100,000</u>	<u>50,000</u>
Unit Cost Multipliers	.400		.500	
*Routine Only				

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2307 (Cont.)ADEQUATE COST DATA and COST FINDING 08-86

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Example of Component Allocation: Utilities

In addition to the facts in the prior example, the provider has established, in accordance with §§2302.8 and 2313.1, a unique cost center called "Utilities." The cost center is used to accumulate the cost of all utilities. The cost center includes electricity costs of \$200,000 (\$45,000 is separately metered and applies to the SNF). In addition, other utilities, not separately metered, total \$400,000. Overhead allocated from other cost centers totals \$100,000. There are no supervisory costs in this cost center.

	Electricity				Other Ut
	Hospital		SNF		
	Stat. (Sq.Ft.)	Cost	Stat. (Sq.Ft.)	Cost	
A&G	25,000	15,500			25,000
Operation of Plant	75,000	46,500			75,000
Dietary	10,000	6,200			10,000
Radiology	20,000	12,400			20,000
Laboratory	12,500	7,750			12,500
Adult & Ped.	100,000	62,000			100,000
Special Care	7,000	4,340			7,000
SNF-Certified *			70,000	31,500	70,000
SNF-Noncertified *			30,000	13,500	30,000
Gift Shop	500	310			500
	<u>250,000</u>	<u>155,000</u>	<u>100,000</u>	<u>45,000</u>	<u>350,000</u>
Unit Cost Multipliers	.62		.45		1.142857
*Routine Only					