**DEPARTMENT OF HEALTH & HUMAN SERVICES** **Office of Inspector General**

**Office of Audit Services, Region V**
**233 North Michigan Avenue**
**Suite 1360**
**Chicago, IL 60601**

December 16, 2009

Report Number: A-05-08-00008

Mr. Thomas Crawford
President and Chief Executive Officer
St. Vincent Frankfort Hospital
1300 South Jackson St.
Frankfort, Indiana 46041

Dear Mr. Crawford:

Enclosed is the U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG), final report entitled "Review of Select Medicare Conditions of Participation and Costs Claimed at St. Vincent Frankfort Hospital from July 1, 2003, Through June 30, 2006." We will forward a copy of this report to the HHS action official noted on the following page for review and any action deemed necessary.

The HHS action official will make final determination as to actions taken on all matters reported. We request that you respond to this official within 30 days from the date of this letter. Your response should present any comments or additional information that you believe may have a bearing on the final determination.

Section 8L of the Inspector General Act, 5 U.S.C. App., requires that OIG post its publicly available reports on the OIG Web site. Accordingly, this report will be posted at http://oig.hhs.gov.

If you have any questions or comments about this report, please do not hesitate to call me, or contact Jaime Saucedo, Audit Manager, at (312) 353-8693 or through email at Jaime.Saucedo@oig.hhs.gov. Please refer to report number A-05-08-00008 in all correspondence.

Sincerely,

/Stephen Slamar/
Acting Regional Inspector General
for Audit Services

Enclosure

**Direct Reply to HHS Action Official:**

Nanette Foster Reilly, Consortium Administrator
Consortium for Financial Management & Fee for Service Operations
Centers for Medicare & Medicaid Services
601 East 12th Street, Room 235
Kansas City, Missouri 64106

Department of Health and Human Services

**OFFICE OF INSPECTOR GENERAL**

# REVIEW OF SELECT MEDICARE CONDITIONS OF PARTICIPATION AND COSTS CLAIMED AT ST. VINCENT FRANKFORT HOSPITAL FROM JULY 1, 2003, THROUGH JUNE 30, 2006


Daniel R. Levinson
Inspector General

December 2009
A-05-08-00008

# *Office of Inspector General*

http://oig.hhs.gov

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at http://oig.hhs.gov

Section 8L of the Inspector General Act, 5 U.S.C. App., requires that OIG post its publicly available reports on the OIG Web site.

## OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS

The designation of financial or management practices as questionable, a recommendation for the disallowance of costs incurred or claimed, and any other conclusions and recommendations in this report represent the findings and opinions of OAS. Authorized officials of the HHS operating divisions will make final determination on these matters.

# EXECUTIVE SUMMARY

## BACKGROUND

Section 4201 of the Balanced Budget Act of 1997, P. L. No. 105-33, Social Security Act, § 1820, 42 U.S.C. § 1395i-4, authorized States to establish Medicare Rural Hospital Flexibility Programs and to designate certain facilities as Critical Access Hospitals (CAH). CAHs must meet certain Medicare Conditions of Participation (CoP) (42 CFR pt. 485, subpart F) and guidelines established by the Centers for Medicare & Medicaid Services (CMS), which administers the Medicare program.

Section 405(e) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), P. L. No. 108-173, Social Security Act, § 1820(c)(2)(B)(iii), 42 U.S.C. § 1395i-4(c)(2)(B)(iii), allowed CAHs to have up to 25 inpatient beds that could be used for acute care or swing-bed services, with CMS approval. Section 405(a) of the MMA, Social Security Act §§ 1814(l), 1834(g)(1) and 1883(a)(3), 42 U.S.C. §§ 1395f(l), 1395m(g)(1) and 1395tt(a)(3), allowed CAHs to receive Medicare reimbursement totaling 101 percent of allowable, allocable, and reasonable costs for payments for services furnished during cost reporting periods beginning on or after January 1, 2004.

St. Vincent Frankfort Hospital (the hospital), located in Frankfort, Indiana, is one of thirteen hospitals in St. Vincent Health Inc., which is owned by Ascension Health, a Missouri-based non-profit corporation. On November 27, 2000, the State of Indiana designated the hospital a CAH providing inpatient and outpatient services. The hospital received Medicare reimbursement totaling $15.3 million for costs reported on its 2004, 2005, and 2006 Medicare cost reports.

## OBJECTIVES

Our objectives were to determine whether the hospital complied with select Medicare CoP and reported costs that were allowable, allocable, and reasonable on its 2004, 2005, and 2006 Medicare cost reports in accordance with Federal requirements.

## SUMMARY OF FINDINGS

The hospital reported $62,945 for unallowable costs on its 2005 and 2006 Medicare cost reports. The hospital reported late lease payments of $61,912 and lobbying costs of $1,033 on its 2005 and 2006 Medicare cost reports, respectively. The hospital said these costs were inadvertently included in its costs reports.

## RECOMMENDATIONS

We recommend that the hospital:

- revise and resubmit its 2005 and 2006 Medicare cost reports to properly reflect the exclusion of the $62,945 in unallowable costs; and

- ensure that it only reports allowable costs on future Medicare cost reports.

## HOSPITAL COMMENTS

In written comments on our draft report, the hospital disagreed with our finding related to noncompliance with the 25 inpatient bed limit. The hospital agreed that building lease expenses and lobbying costs were inappropriately reported on its 2005 and 2006 costs reports. The hospital said that it had inadvertently included these costs in its cost reports and has since submitted a copy of our draft report and a letter to its fiscal intermediary disclosing these errors and requesting guidance on how the fiscal intermediary would like to correct the errors.

The hospital's comments are included in their entirety as the Appendix, except for personally identifiable information.

## OFFICE OF INSPECTOR GENERAL RESPONSE

After reviewing the hospital's comments, we removed our finding and recommendation related to the 25 bed limit.

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# INTRODUCTION

## BACKGROUND

### Critical Access Hospitals

Section 4201 of the Balanced Budget Act of 1997, P. L. No. 105-33, Social Security Act, § 1820, 42 U.S.C. § 1395i-4, authorized States to establish Medicare Rural Hospital Flexibility Programs and to designate certain facilities as Critical Access Hospitals (CAH). CAHs must meet certain Medicare Conditions of Participation (CoP) (42 CFR pt. 485, subpart F) and guidelines established by the Centers for Medicare & Medicaid Services (CMS), which administers the Medicare program.

Section 405(e) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), P. L. No. 108-173, Social Security Act, § 1820(c)(2)(B)(iii), 42 U.S.C. § 1395i-4(c)(2)(B)(iii), allowed CAHs to have up to 25 inpatient beds that could be used for acute care or swing-bed services, with CMS approval.[1] Section 405(a) of the MMA, Social Security Act §§ 1814(l), 1834(g)(1) and 1883(a)(3), 42 U.S.C. §§ 1395f(l), 1395m(g)(1) and 1395tt(a)(3), allowed CAHs to receive Medicare reimbursement totaling 101 percent of allowable, allocable, and reasonable costs for payments for services furnished during cost reporting periods beginning on or after January 1, 2004.

### St. Vincent Frankfort Hospital

St. Vincent Frankfort Hospital (the hospital), located in Frankfort, Indiana, is one of thirteen hospitals in St. Vincent Health Inc., which is owned by Ascension Health, a Missouri-based non-profit corporation. On November 27, 2000, the State of Indiana designated the hospital a necessary provider and CAH under 42 CFR § 485.606. The hospital provides inpatient and outpatient services. The hospital received Medicare reimbursement totaling $15.3 million for costs reported on its 2004, 2005, and 2006 Medicare cost reports.

## OBJECTIVES, SCOPE, AND METHODOLOGY

### Objectives

Our objectives were to determine whether the hospital complied with select Medicare CoP and reported costs that were allowable, allocable, and reasonable on its 2004, 2005, and 2006 Medicare cost reports in accordance with Federal requirements.

### Scope

We reviewed the hospital's compliance with select Medicare CoP and costs reported for the period July 1, 2003, through June 30, 2006.

[1] A swing-bed can be used interchangeably for either inpatient care or skilled nursing care. A patient "swings" or transitions from receiving inpatient services to receiving skilled nursing services.

We limited our internal control review to obtaining an overall understanding of the hospital's policies and procedures for complying with the Medicare CoP and reporting costs on its Medicare cost reports.

We performed our fieldwork at the hospital in Frankfort, Indiana.

### Methodology

To accomplish our objectives, we:

- reviewed applicable Federal CAH requirements;
- reviewed the hospital's policies and procedures related to compliance with select Medicare CoP and cost reporting requirements;
- analyzed the hospital's financial statements and Medicare cost reports for the audit period and determined whether reported costs were allowable, allocable, and reasonable; and
- observed the number of inpatient beds available for use on November 27, 2007, and reviewed inventory records for the audit period.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

## FINDINGS AND RECOMMENDATIONS

The hospital reported $62,945 for unallowable costs on its 2005 and 2006 Medicare cost reports. The hospital reported late lease payments of $61,912 and lobbying costs of $1,033 on its 2005 and 2006 Medicare cost reports, respectively. The hospital said these costs were inadvertently included in its costs reports.

## UNALLOWABLE COSTS

The hospital reported unallowable costs totaling $62,945 related to late lease payments ($61,912) and lobbying costs ($1,033) on its 2005 and 2006 Medicare cost reports, respectively.

### Late Lease Payment Fees

Federal regulations (42 CFR § 413.9) state that a hospital's costs must be related to patient care. Additionally, the CMS Provider Reimbursement Manual (PRM), chapter 21, section 2102.1, titled "Reasonable Costs," states that actual costs be paid to the extent they are reasonable, that the provider seeks to minimize its costs, and that its actual costs do not exceed what a prudent and cost conscious buyer pays for a given item or service. If costs are determined to exceed the

level that such buyers incur, in the absence of clear evidence that the higher costs were unavoidable, the excess costs are not reimbursable under the program. Furthermore, section 2103, titled "Prudent Buyer," states, "Any alert and cost conscious buyer seeks such [cost cutting] advantages, and it is expected that Medicare providers of services will also seek them."

Contrary to Medicare requirements, the hospital reported $61,912 for unallowable late fees and related interest penalties on its 2005 Medicare cost report because the hospital made several late payments for its lease. As a penalty for making late payments, the hospital paid a 5 percent late fee and an overdue interest penalty. Because the hospital did not seek to minimize its costs, the late fees and interest penalties were unallowable.

### Lobbying Costs

The CMS PRM, chapter 21, section 2139, titled "Political and Lobbying Activities," states, "Provider political and lobbying activities are not related to the care of patients. Therefore, costs incurred for such activities are unallowable." Furthermore, the PRM, section 2139.3, titled "Organization Dues Related to Lobbying and Political Activities," states, "Trade or other organizations and associations often engage in lobbying and political activities as part of their activities. Therefore . . ., the portion of an organization's dues or other payments related to these activities, including special assessments, is an unallowable cost."

Contrary to Medicare requirements, the hospital reported $1,033 for unallowable lobbying costs on its 2006 Medicare cost report for the lobbying activities' portion of association dues payments.

## RECOMMENDATIONS

We recommend that the hospital:

- revise and resubmit its 2005 and 2006 Medicare cost reports to properly reflect the exclusion of the $62,945 in unallowable costs; and

- ensure that it only reports allowable costs on future Medicare cost reports.

## HOSPITAL COMMENTS

In written comments on our draft report, the hospital disagreed with our finding related to noncompliance with the 25 inpatient bed limit. The hospital agreed that building lease expenses and lobbying costs were inappropriately reported on its 2005 and 2006 costs reports. The hospital said that it had inadvertently included these costs in its cost reports and has since submitted a copy of our draft report and a letter to its fiscal intermediary disclosing these errors and requesting guidance on how the fiscal intermediary would like to correct the errors.

The hospital's comments are included in their entirety as the Appendix, except for personally identifiable information.

## OFFICE OF INSPECTOR GENERAL RESPONSE

After reviewing the hospital's comments, we removed our finding and recommendation related to the 25 bed limit.

# APPENDIX

# APPENDIX: HOSPITAL COMMENTS

St. Vincent
Frankfort Hospital

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Fax 765-656-3260

www.stvincent.org

August 7, 2009

Marc Gustafson
Regional Inspector General for Audit Services
Office of the Inspector General
233 North Michigan Avenue
Chicago, IL 60601

Re: Response to Draft Audit Report A-05-08-0008

Dear Mr. Gustafson:

This letter serves as St. Vincent Frankfort Hospital's (the "Hospital's") response to the Department of Health and Human Services, Office of the Inspector General ("OIG") draft audit report entitled, *"Review of Select Medicare Conditions of Participation and Costs Claimed at St. Vincent Frankfort Hospital from July 1, 2003 - June 30, 2006."* The Hospital's responses to the OIG's recommendations are detailed below.

A member of ASCENSION HEALTH

St. Vincent's Core Values

We are called to:

**Service of the Poor**
Generousity of spirit for persons most in need.

**Reverence**
Respect and compassion for the dignity and diversity of life.

**Integrity**
Inspiring trust through personal leadership.

**Wisdom**
Integrating excellence and stewardship.

**Creativity**
Courageous innovation.

**Dedication**
Affirming the hope and joy of our ministry.

**OIG Recommendation 1: The OIG recommends that the hospital ensure it is compliant with the Medicare CoP related to the 25 bed limit for inpatient beds.**

**Response to OIG Recommendation 1:*** The Hospital disagrees with the OIG's determination that it was noncompliant with the Medicare CoP that limits the inpatient bed count for Critical Access Hospitals ("CAHs") to 25. The Hospital maintains that it has at all times operated with no more than 25 inpatient beds, consistent with CMS guidance. The Hospital believes the OIG's determination is inconsistent with available CMS guidance on bed count upon which the Hospital relied. Based on that guidance, the two spare beds and four cribs located in a storage area inside the Hospital that is not equipped for patient care should not be counted toward the 25 inpatient bed limit, as the OIG report concludes. However, the Hospital has complied with the OIG's interpretation of the Federal requirements for CAHs since this issue was raised during the review, and will continue to do so, by not storing its change-out beds and cribs in an area that is either in or adjacent to the Hospital. The available guidance upon which the Hospital relied is explained below.



*Office of Inspector General Note—The auditee's response to the OIG's first recommendation is no longer applicable because the finding or issue referred to by the auditee is not included in this report.

Medicare regulation 42 C.F.R. 485.620(a) limits CAHs to 25 inpatient beds that can be used for inpatient acute care or swing bed services. The Interpretive Guidelines for CAHs in Appendix W of the State Operations Manual ("SOM") state that only hospital-type beds that are located in or adjoining any location where the beds could be used for inpatient care should be counted. The Hospital's storage area where the spare beds and cribs were kept is not adjacent to an area of the Hospital where inpatient care is rendered. It is located in an older portion of the Hospital that is used entirely for storage and is not equipped for patient care. This area was built in the 1950s and no longer is suitable for inpatient care.

Based on instructions from CMS in a 2004 "Open Door Forum," the Hospital was operating with the understanding that beds that are used for "change out" purposes do not count towards the 25 bed limit. On September 28, 2004, Dr. Richard Lawler of CMS, presented on the topic of Condition of Participation 485.620(a) Standard: Number of Beds. Spencer Grover, Vice President of the Indiana Hospital Association, attended the discussion and presented the information from CMS at the Indiana Rural Health Association's Critical Access Hospital Benchmarking Task Force Meeting on December 9, 2004. The minutes of this meeting reflect that hospitals were instructed that "change out beds" are not counted toward the 25 bed limit. The comments in the minutes state that pediatric beds and cribs are not able to fit adults. These beds can be moved out and an adult "hospital type" bed can be moved in as long as the changed out beds are removed and out of service with no sheets or blankets. The Hospital's Chief Nursing Officer was in attendance at the meeting, and the Hospital relied on this information in its operations.

The Hospital's spare beds are used only in the event that one of the inpatient beds needs to be repaired. When a bed breaks, it is either swapped out for a spare bed while the broken bed is being repaired or a spare bed is used for parts. The spare beds are never used in addition to the 25 inpatient beds. In the past, the spare beds have been kept in an unheated garage that is not attached to the Hospital. However, the Hospital's maintenance crew observed that the cold weather has proven harmful to the functionality of the spare beds. They were moved into the heated storage unit so that they could more easily become operational when needed for spare parts or to swap out for a broken bed.

Because of the age of the Hospital's inpatient beds, it is particularly important to the Hospital that spare beds are kept available for use when a bed breaks down. The beds were manufactured in 1993 and 1994 and it has proven difficult in the past for the Hospital's maintenance department to repair the beds due to discontinuance and unavailability of spare bed parts. In the past, the Hospital's maintenance department has even had to procure parts from old beds at other

facilities in order to repair the Hospital's beds. In order for the Hospital to maintain 25 inpatient beds, it is necessary to keep the spare beds in the Hospital's storage unit.

The spare cribs are also used only for "change out" purposes. That is, when a crib is needed for a young child, a hospital-type bed from the inpatient unit is changed out for one of the cribs in storage and removed from service. The cribs are never used in addition to the hospital-type beds in the inpatient unit. When a bed is changed out for a crib, it is placed in storage until the crib is no longer needed. The SOM Interpretive Guidelines for CAHs specifically exclude newborn bassinets and isolettes for well-baby boarders. Like bassinettes, cribs are a specific type of bed that can only be used for small children. Cribs are not available for use as inpatient beds for the majority of the Hospital's patients. Because of this, cribs are not considered hospital-type beds, and should not be counted toward the 25 bed limit.

The Hospital's interpretation of the CMS' policy on CAH bed count is also consistent with the CMS' policy for counting the number of beds in a hospital for purposes of determining a hospital's indirect medical education ("IME") costs. For purposes of calculating IME payment, the number of beds in a hospital is determined by counting the number of available bed days during the cost reporting period and dividing that number by the number of days in the cost reporting period. 42 C.F.R. 412.105(b). Although not directly applicable to CAHs, this represents one of the few, if not only, other sources of CMS guidance on determining a Hospital's bed count for Medicare purposes.

Similar to CMS' instructions for counting CAH beds, the count of available beds for IME purposes excludes beds used for outpatient observation services, beds or bassinets in the healthy newborn nursery, and beds in excluded distinct part hospital units. CMS manual instructions for counting beds for IME purposes states that to be counted, a bed must be permanently maintained for lodging inpatients and it must be available for use and housed in patient rooms or wards. Provider Reimbursement Manual, Section 2405.3.

Additionally, CMS regulations state that the count of available bed days for IME purposes excludes bed days associated with beds in a unit or ward that could not be made available for inpatient occupancy within 24 hours for 30 consecutive days. 42 C.F.R. 412.105(b). Further, in the preamble to its Final Rule in the August 11, 2004 Federal Register, coincidentally this same Final Rule included guidance on the revision of the CAH bed limit to 25 beds, CMS explained that to be counted, beds must be able to be staffed for inpatient care either by nurses on staff or from a nurse registry within 24 to 48 hours, and that this can generally be tested by determining whether they are located in a unit that is otherwise staffed

and occupied. CMS also stated that it does not believe that an accurate bed count should include beds that are essentially hypothetical in nature; for example, when the beds are on a floor that is not used for inpatient care throughout the entire cost reporting period. 69 F.R. No. 154 at pg. 49,094.

Such is the case for the spare beds that were located in the Hospital's storage area. These beds may be swapped out for other hospital-type beds, but were never used in addition to the Hospital's 25 beds in the inpatient unit. The Hospital's spare beds were maintained in an area that is not equipped for patient care, nor could it be under current hospital licensure and CoP facility requirements. This is merely a heated storage area. The area also does not adjoin other inpatient areas. The Hospital placed its spare beds there to better maintain the quality of its operating compliment of 25 beds.

A review of the Hospital's daily census was conducted during the October 2007 OIG audit. The Hospital's daily census confirmed that the two spare beds and 4 cribs were never used in addition to the 25 inpatient beds. They were only used for "change out" purposes. Therefore, the Hospital maintains that it was in compliance with CMS' stated policy regarding the bed count for a CAH. Storing the spare and change out beds in an unheated storage area not in or adjacent to the Hospital will, in the long run, only increase the costs of maintaining a quality supply of beds which, since the Hospital is a CAH increase the costs to the Medicare program.

In conclusion, the Hospital believes that the OIG's interpretation of CAH available inpatient bed count is inconsistent with CMS guidance. It also leads to impractical results. CAHs must be able to maintain spare beds and parts, as well and special pediatric beds for small children, in order to provide quality patient care in a cost efficient manner. If the OIG's interpretation is what CMS intended, then guidance should be issued to clarify CMS' policy on CAH bed count.

**OIG Recommendation 2: The OIG recommends that the hospital revise and resubmit its 2005 and 2006 Medicare cost reports, if not settled, to properly reflect the exclusion of the $62,945 in unallowable costs.**

**OIG Recommendation 3: The OIG recommends that the hospital ensure that it only reports allowable costs on future Medicare cost reports.**

**Response to OIG Recommendations 2 and 3:** The Hospital agrees with the OIG's determination that certain unallowable building lease expenses and lobbying costs were reported on the Hospital's 2005 and 2006 cost reports. These costs were inadvertently included in the Hospital's cost reports. Prior to the issuance of the OIG report, the Hospital's 2005 and 2006 cost reports had been

audited without adjustments for these items and the Notice of Program Reimbursement ("NPR") issued by the fiscal intermediary. The applicable Medicare regulations prohibit hospitals from amending their cost reports as the OIG report suggests, after the NPR has been issued. However, the Hospital has submitted a copy of the OIG's draft audit report and a letter disclosing these errors to its fiscal intermediary and requesting guidance on how the intermediary would like to correct the errors and is currently awaiting a response. The Hospital anticipates that the intermediary will reopen the NPRs to adjust for these matters and the Hospital will fully comply with the fiscal intermediary's plan for corrective action.

The Hospital also agrees with the OIG's recommendation that the hospital ensure that it only reports allowable costs on future Medicare cost reports. As stated above, the reporting of unallowable building lease expenses and lobbying costs on the Hospital's 2005 and 2006 cost reports were inadvertent errors. The Hospital, and System of which it is a part, already have policies governing cost reporting that are designed to comply with all applicable requirements. The Hospital is committed to accurately reporting all costs in compliance with the Medicare regulations.

We appreciate the opportunity to review and respond to the draft audit report. If you have any questions regarding this response, please call me at [redacted].

Very truly yours,

Thomas Crawford

Thomas Crawford
President and Chief Executive Officer
St. Vincent Frankfort Hospital

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Office of Inspector General Note—The deleted text has been redacted because it is personally identifiable information.