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DEPRECIATION, STARTUP, ORGANIZATION COSTS, ACCRUALS & PHYSICIAN COMPENSATION MEDICARE REGULATIONS

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Specializing in RHC reimbursement

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Exhibit One

Medicare Depreciation Rules

108. GUIDELINES FOR CAPITALIZATION OF HISTORICAL COSTS AND IMPROVEMENT COSTS OF DEPRECIABLE ASSETS

108.1 Acquisitions.--If a depreciable asset has at the time of its acquisition an estimated useful **life of at least 2 years and a historical cost of at least $5,000, its cost must be capitalized and written off ratably over the estimated useful life of the asset using one of the approved methods of depreciation**. If a depreciable asset has a historical cost of less than $5,000, or if the asset has a useful life of less than 2 years, its cost is allowable in the year it is acquired, subject to the provisions of §106.

The provider may establish a capitalization policy with lower minimum criteria, but under no circumstances may the above minimum limits be exceeded. For example, a provider may elect to capitalize all assets with an estimated useful life of at least 18 months and a historical cost of at least $4,000. However, it may not elect to capitalize only those assets with a useful life of at least 3 years and a historical cost of more than $6,000.

When items are purchased as an integrated system, all items must be considered as a single asset when applying the capitalization threshold. Items that have a stand alone functional capability may be considered on an item-by-item basis. For example, an integrated system of office furniture (interlocking panels, desk tops that are supported by locking into panels) must be considered as a single asset when applying the threshold. Stand alone office furniture (e.g., chairs, free standing desks) will be considered on an item-by-item basis.

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100. GENERAL

The principles of reimbursement for provider costs provide that payment for services should include depreciation on all depreciable type assets that are used to provide covered services to beneficiaries. This includes assets that may have been fully (or partially) depreciated on the books of the provider but are in use at the time the provider enters the program. The useful lives of such assets are considered not to have ended and depreciation calculated on a revised extended useful life is allowable. Likewise, a depreciation allowance is permitted on assets that are used in a normal standby or emergency capacity.

The three methods of prorating the cost of depreciable assets are: straight line, declining balance, and sum of the years' digits. For assets acquired after July 1970, however, the use of an accelerated method of depreciation is limited to a declining balance method not to exceed 150 percent of the straight-line rate under the criteria stated in §116C. The depreciation method used under the Medicare program for an asset need not correspond to the method used by a provider for non-Medicare purposes.

102. PRINCIPLES

An appropriate allowance for depreciation on buildings and equipment is an allowable cost. The depreciation must be: (a) identifiable and recorded in the provider's accounting records; (b) based on the historical cost of the asset as defined in §104.10 or, in the case of donated assets, the lesser of the fair market value or the net book value at the time of donation (see §114.2); and (c) prorated over the estimated useful life of the asset using an allowable method of depreciation as described in §116.

Depreciation on assets being used by a provider at the time it enters into the title XVIII program is allowed. This applies even though such assets may be fully or partially depreciated on the provider's books.

For all assets acquired before 1966, the provider, at its option, may choose an allowance for depreciation based on a percentage of operating costs. The operating costs to be used are the lower of the provider's 1965 operating costs or the provider's current year's allowable costs. The percent to be applied is 5 percent starting with the year 1966-67, with such percentage being uniformly reduced by one-half percent each succeeding year. The allowance based on operating costs is in addition to a regular depreciation on assets acquired after 1965. However, when the optional allowance is selected, the combined amount of such allowance on pre-1966 assets and the straight-line depreciation on assets acquired or rented after 1965 may not exceed 6 percent of the provider's allowable cost for the current year.

Depreciation is allowed on assets financed with Hill-Burton or other Federal or public funds.

104. DEFINITIONS

Depreciation is that amount which represents a portion of the depreciable asset's cost or other basis which is allocable to a period of operation. The amount of depreciation is determined by the provider's method of depreciation accounting.

The American Institute of Certified Public Accountants defines depreciation as a process of cost allocation:

"Depreciation accounting is a system of accounting which aims to distribute the cost or other basic value of tangible capital assets, less salvage (if any), over the estimated useful life of the unit (which may be a group of assets) in a systematic and rational manner. It is a process of allocation, not of

valuation. Depreciation for the year is the portion of the total charge under such a system that is allocated to the year."

104.1 Depreciable Assets.--Assets that a provider has an economic interest in through ownership (regardless of the manner in which they were acquired) are subject to depreciation. Generally, depreciation is allowable on the assets described below when required in the regular course of providing patient care. Assets which a provider is using under a regular lease arrangement would not be subject to depreciation by the provider. (See §110 on lease-purchase and sale-lease-back agreements.)

In general, assets subject to depreciation are described in the AHA Chart of Accounts for Hospitals, M-58, 15M-8/66-183305, and for the most part are also subject to depreciation for Medicare purposes. However, see the treatment of minor equipment as described below.

104.2 Buildings.--Building includes, in a restrictive sense, the basic structure or shell and additions thereto. The remainder is identified as building equipment.

104.3 Building Equipment.--Building equipment includes attachments to buildings, such as wiring, electrical fixtures, plumbing, elevators, heating system, air conditioning system, etc. The general characteristics of this equipment are: (a) affixed to the building, and not subject to transfer; and (b) a fairly long life, but shorter than the life of the building to which affixed. Since the useful lives of such equipment are shorter than those of the buildings, the equipment may be separated from building cost and depreciated over this shorter useful life.

104.4 Major Moveable Equipment.--The general characteristics of this equipment are: (a) a relatively fixed location in the building; (b) capable of being moved as distinguished from building equipment; (c) a unit cost sufficient to justify ledger control; (d) sufficient size and identity to make control feasible by means of identification tags; and (e) a minimum life of approximately three years. Major moveable equipment includes such items as accounting machines, beds, wheelchairs, desks, vehicles, x-ray machines, etc.

104.5 Minor Equipment.--The general characteristics of this equipment are: (a) in general, no fixed location and subject to use by various departments of the provider's facility; (b) comparatively small in size and unit cost; (c) subject to inventory control; (d) fairly large quantity in use; and, (e) generally, a useful life of approximately 3 years or less. Minor equipment includes such items as waste baskets, bed pans, syringes, catheters, silverware, mops, buckets, etc.

104.6 Land (Non-Depreciable).--Land (non-depreciable) includes the land owned and used in provider operations. Included in the cost of land are the costs of such items as off-site sewer and water lines, public utility charges necessary to service the land, governmental assessments for street paving and sewers, the cost of permanent roadways and grading of a non-depreciable nature, the cost of curbs and sidewalks whose replacement is not the responsibility of the provider, and other land expenditures of a non-depreciable nature. Although land used in the provision of patient care activities is a capital asset, the cost of which is neither depreciable nor amortizable under any circumstances, the historical cost limitations described in §104.10 apply to the valuation of land for purposes of determining allowable interest expense under §§202.1 and 203.

104.7 Land Improvements (Depreciable).--Depreciable land improvements include paving, tunnels, underpasses, on-site sewer and water lines, parking lots, shrubbery, fences, walls, etc. (if replacement is the responsibility of the provider).

104.8 Leasehold Improvements.--Leasehold improvements include betterments and additions made by the lessee to the leased property. Such improvements become the property of the lessor after the expiration of the lease.

104.9 Accounting Records.--The depreciation allowance, to be acceptable, must be adequately supported by the provider's accounting records. For Medicare purposes, a provider may maintain supplementary records apart from formal records, but in a manner similar to that used in maintaining formal records. Appropriate recording of depreciation requires the identification of the depreciable assets in use, the assets' historical costs (or fair market value or net book value, as appropriate, at the time of donation in the case of donated assets (see §114.2)), the assets' dates of acquisition, the method of depreciation, estimated useful lives, and the assets' accumulated depreciation.

104.10 Historical Cost.--

A. General--Historical cost is the cost incurred by the present owner in acquiring the asset and preparing it for use. Generally such cost includes costs that are capitalized under generally accepted accounting principles. For example, in addition to the purchase price, historical cost includes architectural fees, consulting fees, and related legal fees.

When an appraisal of a proprietary provider's depreciable assets is necessary because its property records do not adequately reflect the cost of the facility, the cost based on the appraisal may not exceed the capitalized cost basis of the asset used for Federal income tax purposes. However, when a provider has elected for Federal income tax purposes to expense certain items, e.g., taxes and some carrying charges (such as interest), the historical cost basis for Medicare purposes may include the amount of these expensed items unless excluded under subsection C. Subsection C describes the limitations on the historical cost of assets acquired by hospitals or SNFs on or after July 18, 1984 and before December 1, 1997. Subsection E describes the limitations on the historical cost of assets acquired by all providers on or after December 1, 1997.

For the limitation on the inclusion of settlement costs in the historical cost of assets acquired by hospitals or SNFs on or after July 18, 1984, and for all providers on or after December 1, 1997, see subsections C and E. (See §134.3 for further information on asset values of proprietary providers.)

B. For Depreciable Assets Acquired By All Providers After July 1970 and Before December 1, 1997 and By Hospitals or SNFs Before July 18, 1984.--The historical cost must not exceed the lowest of:

- The acquisition cost of the asset to the new owner,
- The current reproduction cost adjusted for straight-line depreciation over the life of the asset to the time of the purchase, or
- The fair market value at the time of the purchase. (See §104.14.)

C. For Depreciable Assets Acquired By Hospitals or SNFs On or After July 18, 1984 and before December 1, 1997.--The historical cost shall not exceed the lowest of the following:

- The allowable acquisition cost for Medicare purposes of the asset to the owner of record as of July 18, 1984 (or in the case of an asset not in existence as of July 18, 1984, the first owner of record of the asset after that date);
- The acquisition cost of the asset to the new owner; or
- The fair market value of the asset on the date of acquisition.

NOTE: If the acquisition was subject to an enforceable agreement entered into before July 18, 1984, the limitations in subsection B apply.

For the purpose of determining the limitation on historical cost for assets acquired by hospitals and SNFs on or after July 18, 1984:

1. An asset not in existence as of July 18, 1984, includes any asset that physically existed, but was not owned by a hospital or SNF participating in the Medicare program as of July 18, 1984.

2. The acquisition cost to the owner of record is subject to any limitation on historical cost described in subsections A and B above and is not reduced by any depreciation taken by the owner of record.

3. The acquisition cost to the owner of record includes the costs of betterments or improvements that extend the estimated useful life, increase productivity, or significantly improve the safety of an asset. (See §108.2.)

4. The acquisition cost to the owner of record for assets acquired prior to a hospital's or SNF's entry into the Medicare program is the historical cost of the asset when acquired, rather than when the hospital or SNF entered the program.

5. The acquisition cost to the owner of record for assets subject to the optional allowance for depreciation described in §124 is the historical cost established for those assets when the hospital or SNF changed to actual depreciation as described in §126. If the hospital or SNF did not change to actual depreciation as described in §126 for optional allowance assets, the acquisition cost to the owner of record is established by reference to the hospital's or SNF's recorded historical cost of the asset when acquired. If the hospital or SNF has no historical cost records for optional allowance assets, the acquisition cost to the owner of record is established by appraisal.

6. The historical cost of an asset acquired on or after July 18, 1984, may not include costs attributable to the negotiation and settlement of the sale or purchase (by acquisition, merger, or consolidation) of any capital asset for which any payment was previously made under the Medicare program. If payment was made for even one cost of this type, all costs of this type must be excluded from the historical cost. (Neither may such costs be included in allowable costs as period costs.) The costs to be excluded include, but are not limited to, appraisal costs (except those incurred at the request of the intermediary under §132.A.1), legal fees, accounting and administrative costs, travel costs, and the costs of feasibility studies. If payment was made for even one cost of this type, all costs of this type must be excluded from the historical cost and are not otherwise allowable.

EXAMPLE 1: An SNF was constructed in January 1987 at a cost of $15 million and approved for Medicare participation. It was sold in 1992 for $20 million. Its fair market value was $20 million. The allowable acquisition cost to the new owner is $15 million.

EXAMPLE 2: Hospital XYZ was constructed in 1980. At the time of construction, the provider also incurred costs for architectural fees and for legal fees. These costs were capitalized and reimbursed as depreciation.

In January 1985, the facility was sold. The purchaser incurred costs for a feasibility study, appraisal fees, and accounting fees related to the purchase. Because fees related to the acquisition of the asset were previously reimbursed under the Medicare program, the purchaser may not include any of the fees attributable to the sale (the cost of the feasibility study, the appraisal fees, and the accounting fees) in the historical cost of the asset nor can the purchaser include these costs as period costs.

EXAMPLE 3: A hospital was built at a cost of $10 million and began operation in October 1986. It did not participate in the Medicare program. In May 1993, it was sold for $12 million, its fair market value, and approved for Medicare participation. Because the hospital had never participated in the program, the allowable acquisition cost to the new owner for Medicare purposes is $12 million.

EXAMPLE 4: The facts are the same as above except the new owner operated the hospital as a nonparticipating hospital until May 1995. At that time, it was approved for Medicare participation. The acquisition cost is $12 million. The basis for depreciation is the acquisition cost reduced by the depreciation accumulated up to the date of entrance into the program. (See §114.B.)

EXAMPLE 5: A nursing facility was constructed in 1983 for $3 million and has operated since that time as a Medicare approved nursing facility. The facility was purchased in 1992 for $8 million. The purchase was entirely financed with a mortgage. The fair market value at the time of sale was $8 million. As a result of §1861(v)(1)(O) of the Act (§2314(a) of DEFRA), the cost basis in the assets was limited to $3 million. Since the purchase in 1992, the nursing facility has allowed accumulated depreciation of $600,000.

In 1994, the nursing facility was sold to an unrelated party for a down payment of $10,000 and the assumption of the facility's outstanding debt of $8 million. The gain or loss is determined as follows:

Actual sales proceeds	$8,010,000
Net book value determined under §1861(v)(1)(O)*	-$2,400,000
Gain on sale	$5,610,000

* $3 million less $600,000

The result of the transaction is a gain of $5,610,000 on the sale (sales price of $8,010,000 less the net book value under §1861(v)(1)(O) of $2,400,000). The maximum amount of the gain recognized by Medicare is limited to the depreciation previously included in Medicare allowable cost, or $600,000. Since $600,000 is less than the total gain of $5,610,000, the total depreciation taken would be includable in the Medicare cost report as a gain. Had there been a loss on the transaction, the amount of the loss would be limited to $2,400,000, the undepreciated basis of the asset permitted under the program ($3,000,000 minus $600,000).

NOTE: The allowable acquisition cost for the new owner (the 1994 purchaser) is $3 million. For the new owner, interest expense is allowable on only $2,990,000 of the $8 million loan assumed. As described in §203, in determining the amount of the loan on which interest expense is allowable, one looks first to the allowable cost of the facility for program purposes (which in this case is $3 million). From this amount, the owner's investment is subtracted, and the balance is the amount on which interest expense is allowable.

EXAMPLE 6: Tom owns a hospital, which he bought for $1 million in 1980. In 1985, he made improvements of $250,000 which extended the useful life of the building.

In 1990, Tom sells the hospital to Dick for $1.1 million. At this point, the historical cost for Dick would be $1.1 million, the lowest of:

- 1.25 million which is the original cost to Tom plus the $250,000 in improvements;
- $1.1 million purchase price; or
- The fair market value which is at least $1.1 million.

Dick finds that he needs to make improvements before opening for business and spends $500,000. In 1992, Dick sells the hospital to Harry for $2 million. The historical cost to Harry would be $1.25 million, the lowest of:

- $1.25 million, the original cost to Tom plus the $250,000 in improvements made by Tom;
- $2 million purchase price; or
- The fair market value which is at least $2 million.

D. Hospital-Based Providers Other Than SNFs and SNF-Based Providers.--For changes of ownership before December 1, 1997 that involve assets of a hospital-based provider other than an SNF, or assets of an SNF-based provider, the provisions of subsection C are not applicable. A reasonable allocation of the purchase price must be made so the hospital-based provider other than an SNF, or an SNF-based provider is not affected by the limitations described above. The historical cost of providers other than hospitals and SNFs is governed by subsection B.

E. For Depreciable Assets Acquired By All Providers On or After December 1, 1997. -- The historical cost of the asset to the acquirer will be the historical cost less depreciation allowed to the owner of record as of August 5, 1997 (or if an asset did not exist as of August 5, 1997, the first owner of record after August 5, 1997). The asset moves from the hands of the seller to the hands of the buyer at the *assets* net book value defined in §104.23. For purposes of this section, the following apply:

1. An asset that was not in existence as of August 5, 1997 includes an asset that physically existed but was not owned by a provider participating in the Medicare program as of that date.

2. The historical cost to the owner of record is subject to the limitation on historical costs described in section B through D of this section, and is reduced by any depreciation taken by the owner of record. The limitation on historical cost is also applied to the purchase of land, which is a capital asset that is neither depreciable nor amortizable under any circumstances. (See §200 ff for application of the limitation to the cost of land for purposes of determining the allowable interest expense.)

3. Historical cost to the owner of record includes the costs of betterments or improvements that extend the estimated useful life, increase the productivity, or significantly improve the safety of an asset. (See §108.2.)

4. For assets acquired prior to a provider's entrance into the Medicare program, the historical cost to the owner of record is the historical cost when acquired, rather than when the provider entered the program.

5. For assets subject to the optional depreciation allowance as described in §413.139, the historical cost to the owner of record is the historical cost established for those assets when the provider changed to actual depreciation as described in §124. If the provider did not change to actual depreciation, as described in §126, for optional allowance assets, the historical cost to the owner of record is based on the provider's recorded historical cost of the asset when acquired. If the provider has no historical cost records for optional allowance assets, the historical cost to the owner of record is established by appraisal.

6. The historical cost of an asset acquired by hospitals and SNFs on or after July 18, 1984 and by all providers on or after December 1, 1997 may not include costs attributable to the negotiation or settlement of the sale or purchase (by acquisition, merger, or consolidation) of any capital asset for which any payment was previously made under the Medicare program. The costs to be excluded include, but are not limited to, appraisal costs (except those incurred at the request of the intermediary under §132.A.1), legal fees, accounting and administrative costs, travel costs, and the costs of feasibility studies. If payment was made for even one cost of this type, all costs of this type must be excluded from the historical cost and are not otherwise allowable.

NOTE: The change in §1861(v)(1)(O) of the Act as amended by §4404 of the Balanced Budget Act (Pub. L. 105-33) has no effect on the recovery of accelerated depreciation as described in §136.

EXAMPLE 1: An SNF was constructed in 1990 for $25 million by Walter and certified for Medicare participation. It was sold in 1995 for $30 million to Ed. Because of the limitations in C. above, the allowable acquisition cost to Ed is $25 million. Ed sells the SNF in 1998 for $30 million to Zelda. Zelda financed the transaction with $5 M in cash and $25 M in bonds. The limitation on the selling price is determined as follows:

Historical Cost to Ed	$25 million
Salvage Value	$ 1 million
Estimated useful life	32 years
Depreciation	
$25 M - $1 M = $24 M	
$24 M) 32 =	$750,000 per year
Depreciation claimed	$2, 250,000
Net Book Value on Ed's books	$22,750,000

There will be no gain or loss on the transaction to Ed. The historical cost to Zelda is $22,750,000. Zelda's allowable interest expense will be limited to the interest on $22,750,000, less the $5,000,000 paid in cash, or $17,750,000.

EXAMPLE 2: In 1995 Mary buys an SNF for $55 million from Peter who has owned and operated it under the Medicare program since it was built in 1990. The SNF cost $50 million to build and its net book value on Pete's books is $45 million. The allowable acquisition cost to Mary is $50 million. Mary continues to operate it as a Medicare provider and depreciates it at $1,250,000 a year.

In 1998 Mary converts it to a noncertified nursing home. At that time her net book value is $46,250,000. She operates it as such until 1999. She sells it to Paul at the end of 1999 for $55 million. Her net book value at the date of sale is $45 million. Paul has it certified for Medicare participation in 2000. Paul's basis is $45 million, less depreciation taken since his date of purchase.

EXAMPLE 3: In 1990, Sam builds a hospital at the cost of $14 million. He operates it as a nonparticipating hospital until 1998. At that time he sells it for $18 million to Melvin. Melvin makes improvements totaling $3 million and the hospital is certified for Medicare participation in 1999. In 2001 he sells the hospital to Hal for $30 million. The net book value on Melvin's books is $18.4 million. There is no gain or loss on the sale. The historical cost to Hal is $18.4 million.

EXAMPLE 4: Michael buys a SNF in 1983 for $20 million. He operates it as a Medicare certified facility until 1999, at which time he sells it to Warren for $6 million. The net book value at the date of sale is $9 million. There is no gain or loss on the sale. The historical cost to Warren is $9 million.

104.11 Historical Cost - Trade-Ins.--When an asset is acquired by trading-in an asset that was depreciated under the program, the cost of the new asset is the sum of the undepreciated cost (or fair market value if no cost is assigned) of the asset traded-in and any cash or other assets transferred or to be transferred to acquire the new asset. However, if the asset disposed of was acquired by the provider before its participation in the Medicare program and the sum of the undepreciated cost and the cash or other assets transferred or to be transferred exceeds the list price or fair market value of the new asset, the historical cost of the new asset is limited to the lower of its list price or fair market value.

For assets having no historical or appraisal values assigned, the cost basis is the fair market value at the date of disposal of the old asset plus the sum paid but not to exceed the lower of the list price or fair market value of the new asset.

104.12 Appraisals.--For Medicare purposes, the term "appraisal" refers primarily to the process of establishing or reconstructing the historical cost, fair market value or current reproduction cost of an asset. It includes a systematic, analytic determination and the recording and analyzing of property facts, rights, investments, and values based on a personal inspection and inventory of the property. (See §134 ff.)

A. Appraisal Date.--The date selected for establishing the value of fixed assets is called the appraisal date. For example, if December 31, 1967, was established as the appraisal date and the actual physical inventory of fixed assets was taken in February 1968, any additions or dispositions of fixed assets between December 1967 and February 1968 must be taken into account in the appraisal values.

B. Appraised Book Value.--The book value of an asset at the appraisal date is its appraised cost as of the date of acquisition less accumulated depreciation computed on any approved basis up to the appraisal date.

C. Appraisal Expert.--An appraisal expert means an individual or a firm that is experience and specialized in multi-purpose appraisal of plant assets involving the establishing or reconstructing of the historical cost, fair market value, or current reproduction cost of such assets; employs a specially trained and well supervised staff with a complete range of appraisal and cost construction techniques; is experienced in appraisals of plant assets used by providers; and demonstrates a knowledge and understanding of the regulations involving reimbursement principles, particularly those pertinent to depreciation.

104.13 Lease-Purchase Assets.--If a lease is a virtual purchase as described in §110.B and the lessee becomes the owner of the leased asset, the historical cost of the asset is the sum of the deferred charge (the difference between the amount of the rent paid and the amount of rent allowed as rental expense) and any additional payments made to acquire the assets, subject to the limitation on revaluation of assets. (See §110.B.2.)

104.14 Purchase of Facility as Ongoing Operation.--

A. The historical cost of assets when an ongoing facility is purchased through a bona fide sale is determined as follows:

1. For depreciable assets acquired after July 1, 1966, and prior to August 1970, the sale price or portion thereof attributable to the asset must not exceed the fair market value of the asset at the time of the sale.

2. For depreciable assets acquired after July 1970 and in the case of hospitals and SNFs, before July 18, 1984, the historical cost must not exceed the lowest of (1) the acquisition cost of the asset to the new owner, (2) the current reproduction cost adjusted for straight-line depreciation over the life of the asset to the time of the purchase, or (3) the fair market value at the time of the purchase. (See §104.15.)

3. For depreciable assets acquired by hospitals or SNFs on or after July 18, 1984, and not subject to an enforceable agreement, the limitations on historical cost specified in §104.10.C are applicable.

4. For depreciable assets acquired by all providers on or after December 1, 1997, the limitations on historical cost specified in §104.10.E are applicable.

B. For changes of ownership on or after December 1, 1997, no gain or loss is recognized on the sale. For changes of ownership before December 1, 1997, the basis for determining the gain or loss to the seller when the facility was being operated under the program at the time of sale is the sales price.

For assets acquired prior to July 1970, the sale price used by the seller in computing gain or loss for the final cost report must agree with the historical cost used by the new provider in computing depreciation.

For an asset acquired after July 1970, the basis for computing gain or loss to the seller is the sales price without regard to any limitation on the basis for depreciation to the buyer as described in §104.10. (See example 5 in §104.10.C.)

The gain or loss on the sale of each depreciable asset must be determined by allocating the lump sum sale price among all the assets sold (including land, goodwill, and any assets not related to patient care), in accordance with the fair market value of each asset as it was used by the provider at the time of sale. If the buyer and seller cannot agree on an allocation of the sale price, or if they do agree but there is insufficient documentation of the current fair market value of each asset, the intermediary for the selling provider must require an appraisal by an independent appraisal expert to establish the fair market value of each asset and must make an allocation of the sale price in accordance with the appraisal. (See §134 ff.) In any case, the sale price must be allocated among all the assets sold, even when, for example, some of the assets will be disposed of shortly after the sale.

C. If a purchaser cannot demonstrate that the sale was bona fide, the seller's net book value must be used by the purchaser as the basis for depreciation of the asset. In such a case, the purchaser must record the historical cost and accumulated depreciation of the seller recognized under the program, and these are considered as incurred by the purchaser for program purposes, such as application of §§132 ff. (See §1011.4 if related organizations are involved.)

104.15 Fair Market Value.--Fair market value is the price that the asset would bring by bona fide bargaining between well-informed and unrelated buyers and sellers at the date of acquisition. Usually the fair market is the price at which bona fide sales have been consummated for assets of like type, quality, and quantity in a particular market at the time of acquisition.

104.16 Donated Assets.--An asset is considered donated when the provider acquires the asset without making any payment for it in the form of cash, property, or services. When the provider makes any such payment in acquiring the asset, if the payment is less than the fair market value, then

this payment, and not the fair market value, is considered to be the historical cost of the asset. If an asset is exchanged for new debt or the assumption of debt, then the transaction is considered a sale and not a donation. (For the depreciation basis, see §114.2.)

104.17 Useful Life of Depreciable Assets.--The estimated useful life of an asset is its expected useful life to the provider, not necessarily the inherent useful or physical life. In initially selecting a proper useful life for computing depreciation under the Medicare program, the provider may use certain published useful life guidelines. The guidelines used depend on when the asset was acquired. For assets acquired before January 1, 1981, either the Internal Revenue Service (IRS) or the American Hospital Association (AHA) guidelines may be used. For assets acquired on or after January 1, 1981, only the AHA guidelines may be used.

Date Asset Acquired	Useful Life Guidelines
Before 1/1/81	Internal Revenue Service (IRS) guidelines except those offered by the Asset Depreciation Range System) or the 1973 edition of the AHA Chart of Accounts for Hospitals
On or after 1/1/81, but before 1/1/82	1973 edition of the AHA Chart of Accounts for Hospitals
On or after 1/1/82, but before 1/1/83	1978 edition of the AHA Estimated Useful Lives of Depreciable Hospital Assets
On or after 1/1/83, but before 8/1/88	1983 edition of the AHA Estimated Useful Lives of Depreciable Hospital Assets
On or after 8/1/88, but before 3/1/93	1988 edition of the AHA Estimated Useful Lives of Depreciable Hospital Assets (except Table I)
On or after 3/1/93, but before 3/1/98	1993 edition of the AHA Estimated Useful Lives of Depreciable Hospital Assets
On or after 3/1/98, before 5/1/2004	1998 edition of the AHA Estimated Useful Lives of Depreciable Hospital Assets but
On or after 5/1/2004, *before 8/1/2008*	2004 edition of the AHA Estimated Useful Lives of Depreciable Hospital Assets *but*
On or after 8/1/2008	*2008 edition of the AHA Estimated Useful Lives of Depreciable Hospital Assets*

The use of the 1978 or later AHA editions allow more detailed component lives for building and building equipment (e.g., automatic doors, canopies, computer flooring, etc.). Each component may be depreciated separately on the basis of the useful life of each component, rather than on the basis of a single useful life for the entire building.

A composite useful life, as illustrated in the 1973 and 1978 editions, may be used for a class or group of assets. In using the 1988 edition, Table 1, which provides useful life ranges for groups of assets, may not be used.

For assets acquired before December 1, 1997, a purchaser of a used asset must assume a useful life based on the guidelines for new assets. However, if approved by the contractor, the purchaser of a used asset may reduce the useful life based on acceptable factors that affect the establishment of a different useful life as described below.

For used assets acquired on or after December 1, 1997, and subject to the historical cost limitation in 104.10E and 104.14A.4 the purchaser must use the remaining useful life.

Purchased computer software acquired prior to August 1, 1988, is depreciated over the useful life of the hardware if the software is purchased with computer equipment and the cost is not separately stated. If the cost of the software is separately stated, or if the software is purchased independent of the hardware, it must be depreciated over a minimum of 5 years. Purchased computer software purchased on or after August 1, 1988, is depreciated using the applicable edition of the useful life guidelines.

The costs of initial customizing and/or modification of purchased computer software to function with the provider's computer hardware, or to put it into place for use, should be capitalized as part of the historical cost of the software. Such costs are analogous to installation costs of a moveable asset. The costs of internally generated computer software must be expensed, rather than capitalized. For purposes of this section, internally generated computer software means software generated, in whole or in part, by staff internal to the provider. The use of outside consultants to assist the provider's staff in developing a systems change does not change the nature of any resultant software from internally generated to purchased.

The costs of a building addition may be depreciated over the remaining useful life of the primary building to which it is appended, rather than over the inherent physical life of the building addition, if the provider intends to demolish or abandon the primary building and the building addition upon the expiration of the useful life of the primary building. However, the provider must demonstrate to the contractor by convincing evidence a clear intention to demolish or abandon the building addition at the expiration of the useful life of the primary building (e.g., a master building plan which does not provide for any alternative which would have the building addition remain in place beyond demolition or abandonment of the primary building). If the provider's evidence contains alternatives that would extend the useful life of the building addition beyond the remaining useful life of the primary building, a presumption must be made that the useful life of the building addition corresponds with its inherent physical life, and the shorter useful life may not be used.

A different useful life may be approved by the contractor if the provider's request is properly supported by acceptable factors which affect the determination of useful life. Such factors include normal wear and tear, obsolescence due to normal economic and technological changes, climatic and other local conditions, and the provider's policy for repairs and replacement. When the useful life selected differs significantly from that established by the guidelines, the deviation must be based on convincing reasons supported by adequate documentation, generally describing the realization of some unexpected event. Factors such as an expected early sale, retirement, demolition, or abandonment of an asset (however, see exception regarding building additions above), or termination from the Medicare program, may not enter into a determination of the expected useful life of an asset.

104.18 Useful Life - Leasehold Improvements.--The costs of improvements which are the responsibility of the provider under the terms of a lease may be depreciated over the useful life of the improvement or the remaining term of the lease, whichever is shorter. The term of the lease includes any period for which the lease may be renewed, extended, or continued following either an option exercised by the provider or, in the absence of an option, reasonable interpretation of past acts of the lessor and lessee pertaining to renewal, etc., unless the provider establishes, omitting past acts, that it will probably not renew, extend, or continue the lease.

104.19 Salvage Value - Depreciable Assets.--Salvage value is the estimated amount expected to be realized upon the sale or other disposition of the depreciable asset when it is no longer useful to the provider. The amount is ordinarily estimated at the time of acquisition and, except for the declining balance method, is deducted from the cost of the depreciable property to arrive at the basis for depreciation. For example, an asset is purchased for $17,000 with an expected salvage value of $2,000. The basis for depreciation becomes $15,000 (i.e., $17,000 less $2,000) for computing the depreciation.

Thus, if a provider disposes of its assets when they are in good operating condition, the salvage value is higher than it might be if the provider used the assets until their inherent life had been substantially exhausted. Virtually all assets have a salvage value substantial enough to be included in calculating depreciation, and only in the rare instance is salvage value so negligible that it may be ignored.

For assets acquired on or after December 1, 1997, and subject to the historical cost limitation in 104.10E and 104.14A.4, salvage value need not be taken.

104.20 Scrapping.--Scrapping is the physical removal from the provider's premises of tangible personal property which is no longer useful for its intended purpose and is only salable for its scrap or junk value.

104.21 Abandonment.--Abandonment means the permanent retirement of an asset for any future purpose, not merely the provider's ceasing to use the asset for patient care purposes. To claim an abandonment under the program, the provider must have relinquished all rights, title, claim, and possession of the asset with the intention of never reclaiming it or resuming its ownership, possession, or enjoyment.

104.22 Demolition.--The deliberate destruction of a building or other asset resulting in the complete loss of economic value (other than the scrap value) of the asset.

104.23 Net Book Value.--The net book value of the asset is defined as the historical cost under the program less the depreciation recognized under the program.

104.24 Bona Fide Sale.--A bona fide sale contemplates an arm's length transaction between a willing and well informed buyer and seller, neither being under coercion, for reasonable consideration. An arm's-length transaction is a transaction negotiated by unrelated parties, each acting in its own self interest.

106. METHODS FOR WRITING OFF COST OF MINOR EQUIPMENT

Except where prohibited by §108, a provider may treat the cost of the minor equipment needed to operate its facility in any one of the following methods:

(a) The original investment in this equipment is not amortized or depreciated. Any replacements to the base stock are charged to operating expenses. The investment in the base inventory of equipment is adjusted when there is a significant change in the inventory size. For example:

Provider Fiscal Year - July 1 to June 30

Provider Entered Program - July 1, 1966

Original Cost of Minor Equipment in Use at July 1, 1966 - $15,000

Purchases During FY July 1, 1966, to June 30, 1967 ------ $10,000

Minor Equipment Inventory Value at June 30, 1967 ------- $20,000
(Determined for this example to be a significant change in inventory size)

Charges to operating expense in FY ended June 30, 1967, are $5,000. (Purchases of $10,000 less increase in inventory value of $5,000)

(b) The net book value of such items at the time the provider enters the program may be written off ratably over 3 years; that is, one third of the net book value is written off each year. Net book value is the historical cost less previous write-off. The previous write-off should have been computed on the basis of not more than a 3-year life and in equal amounts. A full one-third write-off should have been made in the year of acquisition. If the computation had been based on longer life or a different rate, or both, or if the equipment has been previously written off directly through charges to operating expense, the net book value at the time the provider enters the program is amortized applying a 3-year basis. Thus, any asset over 3 years old, although still in use, is not included. Under this method, any new purchases are also written off ratably over a 3-year period. For example:

Provider Fiscal Year - January 1 to December 31

Provider Entered Program - January 1, 1967

Purchase Date	Acquisition Cost of Minor Equipment in Use on 1/1/67		Recomputed Write-Off To 1/1/67		Net Book Value As Of 1/1/67
1965	$9,000	minus	$6,000	equals	$3,000
1966	6,750	minus	2,250	equals	4,500
				Total	$7,500

Write-Off allowed on above equipment: 1967 - $2,500
1968 - $2,500
1969 - $2,500

(c) Equipment still in use may be categorized (e.g., surgical instruments) and written off ratably over their actual useful lives. Where depreciable equipment had been written off directly through charges to operating expense, or previously inaccurately depreciated due to the provider's method of accounting for minor equipment, a new book value of equipment still in use may be recomputed using the actual useful lives.

Once a provider has applied one of the above methods, that method must be consistently used thereafter unless approval for a change is granted by the intermediary. A request for change must be made no later than the last day of the first month of the accounting year in which the new method is to be employed.

Methods (a) and (b) are not methods of depreciation and the rules of this chapter relevant to depreciation are not applicable.

108. GUIDELINES FOR CAPITALIZATION OF HISTORICAL COSTS AND IMPROVEMENT COSTS OF DEPRECIABLE ASSETS

108.1 Acquisitions.--If a depreciable asset has at the time of its acquisition an estimated useful life of at least 2 years and a historical cost of at least $5,000, its cost must be capitalized and written off ratably over the estimated useful life of the asset using one of the approved methods of depreciation. If a depreciable asset has a historical cost of less than $5,000, or if the asset has a useful life of less than 2 years, its cost is allowable in the year it is acquired, subject to the provisions of §106.

The provider may establish a capitalization policy with lower minimum criteria, but under no circumstances may the above minimum limits be exceeded. For example, a provider may elect to capitalize all assets with an estimated useful life of at least 18 months and a historical cost of at least $4,000. However, it may not elect to capitalize only those assets with a useful life of at least 3 years and a historical cost of more than $6,000.

When items are purchased as an integrated system, all items must be considered as a single asset when applying the capitalization threshold. Items that have a stand alone functional capability may be considered on an item-by-item basis. For example, an integrated system of office furniture (interlocking panels, desk tops that are supported by locking into panels) must be considered as a single asset when applying the threshold. Stand alone office furniture (e.g., chairs, free standing desks) will be considered on an item-by-item basis.

108.2 Betterments and Improvements.--Betterments and improvements extend the life, increase the productivity, or significantly improve the safety (e.g., asbestos removal) of an asset as opposed to repairs and maintenance which either restore the asset to, or maintain it at, its normal or expected service life. Repair and maintenance costs are always allowed in the current accounting period.

For the costs of betterments and improvements, the guidelines established in §108.1 must be followed, i.e., if the cost of a betterment or improvement to an asset is $5,000 or more and the estimated useful life of the asset is extended beyond its original estimated useful life by at least 2 years, or if the productivity of the asset is increased significantly over its original productivity, or the safety of the asset is increased significantly, then this cost must be capitalized and written off ratably over the remaining estimated useful life of the asset as modified by the betterment or improvement. As in the previous section, lower minimum criteria may be used if desired.

110. SALE AND LEASEBACK AND LEASE-PURCHASE AGREEMENTS

A. Sale and Leaseback Agreements - Rental Charges.--

1. The incurred rental specified in the sales agreement entered into by hospitals or SNFs before Oct. 23, 1992, or by other providers at any time, is includable in allowable costs if the agreement is with a nonrelated purchaser involving plant facilities or equipment and the following conditions are met:

o The rental charges are reasonable based on consideration of rental charges of comparable facilities and market conditions in the area; the type, expected life, condition and value of the facilities or equipment rented; and other provisions of the rental agreements;

o Adequate alternate facilities or equipment which would serve the purpose are not or were not available at lower cost; and

o The leasing was based on economic and technical considerations.

2. When a hospital or SNF enters into a sale and leaseback agreement on or after October 23, 1992, or in the case of other providers, when the conditions in subsection A are not met, and the agreement is with a nonrelated purchaser involving plant facilities or equipment, the amount that may be included as rental or lease expense may not exceed the amount that the provider would have included in its allowable costs had the provider retained legal title to the facility or equipment (i.e., the costs of ownership). The costs of ownership include items such as interest expense on mortgages, taxes, depreciation, and insurance costs.

The limitation on the amount that may be included in lease or rental costs applies both on an annual basis and over the useful life of the asset.

a. If in the early years of the lease, the annual lease costs are less than the annual costs of ownership, but in the later years of lease, the annual lease costs are more than the costs of ownership, the limitation is applied as follows.

In the years when the lease costs are less than the costs of ownership, the actual annual lease costs are included in allowable costs. However, in the later years of the lease, when the annual lease costs are greater than the annual ownership costs, the full lease costs may be included so long as, in the aggregate, the total costs of the lease do not exceed the total costs of ownership over the life of the asset.

EXAMPLE: A 10 year lease has lease costs of $10,000 per year. The asset has a useful life of 12 years. The costs of ownership is $11,000 per year for the first 3 years, $9,000 for the next 2 years, and $6,000 a year thereafter, with a total costs of ownership of $93,000.

	Lease	Ownership	Allowable (per year)	Total Cumulative
Years 1-3	$10,000	$11,000	$10,000	$30,000
Years 4-5	$10,000	$ 9,000	$10,000	$20,000
Years 6-9	$10,000	$ 6,000	$10,000	$40,000
Year 10	$10,000	$ 6,000	$ 3,000	$ 3,000
Years 11-12	$ 0	$ 6,000		$ 0
Total	$100,000	$93,000		$93,000

b. If in the early years of the lease, the annual lease costs are greater than the annual ownership costs, but in the later years of the lease the annual lease costs are less than the annual ownership costs, the limitation is applied as follows.

In the years that the annual lease costs exceed the costs of ownership, the provider may carry forward lease costs that are excluded from allowable costs because of the annual limit. The amounts carried forward are included in allowable costs in the years of the lease when the lease costs are less than the annual costs of ownership. However, in any year, the amount of actual annual lease costs plus the amount carried forward may not exceed the annual cost of ownership for that year. In addition, in the aggregate, the amount of rental or lease costs included in allowable costs may not exceed the costs of ownership that the provider could have included in allowable costs had the provider retained legal title to the asset.

EXAMPLE: There is a 10 year lease with lease costs of $9,000 per year. The costs of ownership is $7,000 per year for the first 3 years, $9,000 for the next 2 years, and $10,000 a year thereafter, with a total costs of ownership of $89,000.

		Costs		
	Lease	Ownership (per year)	Allowable (per year)	Total Cumulative
Years 1-3	$9,000	$7,000	$ 7,000*	$21,000
Years 4-5	$9,000	$9,000	$ 9,000	$18,000
Years 6-10	$9,000	$10,000	$10,000**	$50,000
Total		$90,000	$89,000	$89,000

* $1,000 per year is carried forward

** includes $1,000 per year carries forward from years 1-3

NOTE: $1,000 in carry forward costs are not recognized because the total cost of ownership would be exceeded.

B. Lease Purchase Agreements - Rental Charges.--

1. Definition of Virtual Purchase.--

a. For lease transactions of all providers entered into before October 23, 1992, the existence of the following conditions generally establishes that a lease is a virtual purchase.

o The rental charge exceeds rental charges of comparable facilities or equipment in the area;

o The term of the lease is less than the useful life of the facilities or equipment; and

o The provider has the option to renew the lease at a significantly reduced rental, or the provider has the right to purchase the facilities or equipment at a price which appears to be significantly less than what the fair market value of the facilities or equipment would be at the time acquisition by the provider is permitted.

b. For lease transactions of all providers entered into on or after October 23, 1992, a lease that meets any one of the following conditions establishes a virtual purchase.

o The lease transfers title of the facilities or equipment to the lessee during the lease term,

o The lease contains a bargain purchase option,

o The lease term is 75 percent or more of the useful life of the facilities or equipment. This provision is not applicable if the lease begins in the last 25 percent of the useful life of the facilities or equipment, or

o The present value of the minimum lease payments (that is, payments to be made during the lease term, including bargain purchase option, guaranteed residual value, or penalties for failure to renew) equal 90 percent or more of the fair market value of the leased property. This provision is not applicable if the lease begins in the last 25 percent of the useful life of the facilities or equipment. The present value is computed using the lessee's incremental borrowing rate, unless the interest rate implicit in the lease is known and is less than the lessee's incremental borrowing rate, in which case, the interest rate implicit in the lease is used.

2. Treatment of Rental Charges.--If the lease is a virtual purchase, the rental charge is includable in allowable costs only to the extent that it does not exceed the amount which the provider would have included in allowable costs if it had legal title to the asset (the cost of ownership), such as straight line depreciation, insurance, and interest. For purposes of computing the limitation on allowable rental cost, a provider may not include accelerated depreciation in its allowable costs.

The difference between the amount of the rent paid and the amount of rent allowed as rental expense is considered a deferred charge and is treated as follows:

a. If the asset is purchased by the provider, the deferred charge must be capitalized as part of the historical cost of the asset, subject to the limitation on revaluation of assets, and is depreciated over the useful life of the asset.

b. If the asset is returned to the owner, instead of being purchased, the deferred charge may be expensed in the year the asset is returned.

c. If the term of the lease is extended for an additional period of time at a reduced lease cost and the option to purchase still exists, the deferred charge may be expensed to the extent of increasing the reduced rental to an amount not in excess of the cost of ownership.

d. If the term of the lease is extended for an additional period of time at a reduced lease cost and the option to purchase no longer exists, the deferred charge may be expensed to the extent of increasing the reduced rental to a fair rental value.

If the leasee becomes the owner of the leased asset (either by operation of the lease or by other means), the amount considered as depreciation for the purpose of having computed the limitation expressed in the first paragraph

of the section must be used in calculating the limitation on adjustments to depreciation for the purpose of determining any gain or loss upon disposal of an asset under §132.

e. If the provider undergoes a change of ownership (CHOW) during the lease period, and the lease is assigned to the new owner (with no changes to the lease terms), the deferred rental charge is treated as follows:

1. If the CHOW is between or among unrelated entities, any rental amount deferred as of the date of the CHOW is included in the terminating provider's final cost report. The acquiring provider must apply the above limitations in determining the amount of rental charges to be included in its allowable costs. EXCEPTION: If the terms of the lease changed in addition to the assignment of the lease, the new lease must be evaluated to determine if it should still be considered as lease-purchase agreement.

2. If the CHOW is between or among related organizations, the lease is treated as if a CHOW had not occurred (i.e., the deferred rental amount may not be included in the termination provider's final cost report, and the above limitations will continue to apply in determining the amount of rental expense that may be included in the allowable costs of the acquiring provider.

EXAMPLE: A provider leased the following asset for 5 years at a cost of $75,000 per year. The asset costs $300,000 and has a useful life of 6 years. The cost of ownership was determined as follows:

Cost	$300,000
Useful Life	6 years
Depreciation	$50,000 per year
Insurance	$ 3,000 per year
Interest	$12,000 per year

The yearly cost of ownership is $65,000. It was determined that this was a virtual purchase. The rental charge included in allowable expense is limited to $65,000 and the difference of $10,000 is deferred.

The asset is then purchased by the provider at the end of the lease for $30,000. The basis of the asset is $30,000 plus 5 years deferred charges at $10,000 or a total of $80,000. The useful life is 6 years and the salvage value is $2,000. The purchaser of a used asset must assume a useful life based on the guidelines for new assets unless a different useful life is justified to the intermediary. (See §104.17.)

The provider keeps the asset for 4 years and sells it for $35,000. The gain or loss on the sale is determined as follows:

Basis	$80,000
Depreciation	$52,000
Undepreciated Basis	$28,000
Sales Price	$35,000
Gain	$ 7,000

The maximum amount of the gain recognized by Medicare is limited to depreciation previously included in Medicare allowable cost or $52,000. Had

there been a loss on the transaction, the amount of the loss would be limited to $28,000, the undepreciated basis of the asset permitted under the program.

3. Effect of Funded Depreciation.--When a provider which has funded depreciation available leases an asset and it is determined that the lease is a virtual purchase, the lease charge is recognized as described in subsection 2. However, in determining the cost of ownership for comparison to the cost of leasing, the provider must not include a factor representing imputed interest expense. Since the provider had funded depreciation available, it would not have incurred interest expense related to the purchase. While the implicit interest expense cannot be included in determining the limitation, it is not unallowable. Rather, the implicit interest is deferred as part of the excess of the lease payment over the costs of ownership when funded depreciation is available. The excess of any reasonable rental or lease charge over the costs of ownership is not disallowed. As described in subsection 2, this excess is deferred and either (1) reimbursed when the asset is returned to the lessor or (2) included in the historical cost basis of the asset when the asset is purchased by the lessee.

111. ASSUMPTION OF LEASE AT LESS THAN FAIR RENTAL VALUE

There are some situations in which a provider may obtain lease rights for less than fair rental value when, for example, a provider assumes an existing lease on a tangible asset(s) as part of the purchase of a group of assets, which includes the favorable lease. In such situations, the provider is actually paying to obtain the favorable lease. If the provider and the entity from which the lease is assumed are not related within the meaning of Chapter 10, and if the essential elements of the lease (e.g., lease payments, lease term, responsibilities of lessor and lessee) remain unchanged as a result of the lease assumption, the reasonable amount paid for purposes of obtaining the lease (in excess of the actual amount of rent which must be paid under the lease) may be ratably amortized over the life of the lease (excluding renewal periods) so long as the leased assets are used to render patient care. If the lease is terminated before the amortization period is completed, the unamortized amount may be included in allowable cost in the year of termination. The reasonable amount for purposes of obtaining the favorable lease must be documented as having been paid for the lease, and it must be shown that the amount of rent required under the lease plus the amount paid for purposes of obtaining the favorable lease does not exceed the fair rental value of the lease.

EXAMPLE: In 1985, Corporation A purchases the assets of Hospital B, a provider corporation not related to Corporation A within the meaning of Chapter 10. Corporation A continues operation of the hospital as a participating provider. The assets purchased include a hospital building, building equipment, major moveable equipment, land, and a lease on a storage building located on property adjacent to the hospital property. The storage building is used to store provider assets related to patient care. The storage building and the land upon which it is situated is owned by Partnership XYZ (lessor), an organization not related to either Corporation A or Corporation B within the meaning of Chapter 10.

In 1980, when the lease was originally negotiated between Partnership XYZ and Provider B, the lease provided for a reasonable first year rental amount to be increased no more than 5 percent per year. The term of the lease was 10 years and the lease was assignable. From 1980 through the date of the sale of the hospital to Corporation A, fair rental values for similar rental properties have increased at the rate of 8 percent per year.

Corporation A, in recognition of the fact that it is assuming a favorable lease (at less than fair rental value), paid an additional, reasonable amount to Hospital B for the favorable lease. The amount paid in recognition of the favorable lease is

documented in the sales agreement. The additional amount paid for the favorable lease may be ratably amortized over the remaining life of the lease (5 years), so long as the building continues to be used for a purpose related to patient care.

112. ALLOWANCE FOR DEPRECIATION ON FACILITIES LEASED FOR NOMINAL AMOUNT

A considerable number of providers lease their facilities from municipalities at a nominal rental (usually for $1.00 per year) with the lease generally covering the useful life of the facility. Under most lease arrangements, the tenant (lessee) maintains the property and pays the cost of any improvement or addition to the facility. When such improvement or addition is made, the lessee may properly depreciate its cost. The depreciation allowance is includable in allowable cost. At the end of the lease, improvements and additions made by the lessee become the property of the lessor. However, in some instances, the lease agreement provides that title to any additions or improvements is to revert to the owner in the first year they are used. In such cases, the cost of any addition or improvement is similarly depreciated, and the depreciation allowance is also includable in allowable cost.

It is the general practice of the provider to include in its charges (and cost) an amount to cover depreciation on the leased facilities as distinguished from capital improvements made by the lessee. In recognition of this practice, most third parties that reimburse providers on the basis of cost allow depreciation (but not interest) on facilities that have been leased for a nominal rental. In view of this and since the lease arrangement in such cases generally contemplates the occupancy by the lessee for the period of the useful life of the facility, depreciation on the leased facility may be included in allowable cost under the conditions described below.

112.1 Analysis of Lease Arrangement.--Each case must be decided on its own merits for depreciation to be allowed. The lease must contemplate that the lessee will make any necessary improvements and properly maintain the facility. The lease may and frequently does cover the useful life of the asset. If not, however, as in the case of a year to year lease, such lease is examined closely to determine whether the renewal and other provisions of the lease contemplate that the provider will use the facility to the extent of its useful life. Where the intent and provisions of the year to year lease permit the provider to have the benefit of the useful life of the facility, such lease is treated, for depreciation purposes, in the same manner as a long-term lease that covers the useful life of the asset. The actions of the lessee and lessor in such cases should indicate that the intent of both parties is to continue the lease arrangements for the useful life of the asset. Of course, other facts are considered together with the past actions of the lessee and lessor in order to determine whether or not the asset will and can be used by the lessee for the asset's full useful life.

The lease should have no restrictions on the free use of the facility by the lessee. In addition, the lease should not provide for any indirect benefits to the lessor or to those connected with the lessor. For example, if the lease requires that the lessee furnish free hospital services to the employees of the lessor, then depreciation is not allowed. In such case, the cost of the services furnished to the lessor's employees is appropriately included when determining Medicare's share of allowable costs.

When the provider pays or contributes to the lessor any funds which are to be used for retiring the lessor's bonds or notes issued for the facility, such payments are considered rental payments. These rental payments, to the extent they are reasonable, are considered an allowable cost. Also, any general contribution by the lessee to the lessor is considered a rental payment for the use of the facility. When either of such rental payments is allowable as cost, depreciation on the leased facility is not an allowable cost item.

Any questions on the legal interpretation of the lease as it relates to the criteria discussed above, should be submitted through the Bureau of Health Insurance regional office for an opinion from the regional attorney.

112.2 Basis and Method for Depreciation.--For depreciation cost allowance purposes under the program, the leased asset should be treated as tough the lessor an lessee were one and the same. All the cost principles and reimbursement manual sections on depreciation would be applicable to such assets. For example, the basis for depreciation will be the historical cost of the asset to the lessor adjusted for past depreciation. If historical cost records are not available, a proper appraisal for establishing the historical cost would be acceptable. Where the leased facility is later purchased by the provider, the facility's undepreciated balance on the date of title transfer or the purchase price, which ever is lower, will, for further depreciation purposes, be considered the unrecovered cost of the facility.

The following illustration demonstrates the computation of depreciation on the leased facility and amortization on improvements made to that facility.

FACTS

Historical cost of the leased facility at acquisition date--7/1/56	$520,000
Estimated salvage valuE	$ 20,000
Estimated useful life of the facility	40 years
Life of the lease effective at 7/1/60	35 years
Method of depreciation	Straight Line
Leasehold improvement 7/1/65	$ 90,000
Estimated useful life of improvement	30 years

COMPUTATION OF DEPRECIATION

Historical cost of building	$520,000
Less: Estimated salvage value	20,000
Basis for depreciation	$500,000
Annual rate of depreciation based on 40 year life	2.5%
Annual depreciation on building	$ 12,500
Accumulated depreciation on 7/1/66 (Date of entrance into Medicare program)(10 years at $12,500	$125,000

COMPUTATION OF AMORTIZATION ON IMPROVEMENT

Cost of leasehold improvement	$ 90,000	
Useful life--30 years		
Annual amortization	$ 90,000 ÷ 30 years	$ 3,000
Accumulated amortization on 7/1/66 (Date of entrance into Medicare program)		$ 3,000

TOTAL ANNUAL DEPRECIATION AND AMORTIZATION

Annual depreciation on facility	$12,500
Annual amortization on improvement	3,000
Total	$15,500

113. LEASING ARRANGEMENTS THAT REQUIRE THE LESSOR TO FURNISH NORMAL BASIC SERVICES

113.1 Lessor - Lessee Arrangements.--Owners of some facilities enter into agreements providing for leasing a stated number of beds in their institutions. Under these arrangements, the lessor-operator of the facility agrees to provide the equipment, furnishings, supplies, meals, maintenance and janitorial services necessary for the lessee's operation of a portion of the premises, usually as skilled nursing facility under the Medicare program. Usually, the lessor also provides all necessary nursing services or at least provides an option for the lessee to use the lessor's nursing services. The arrangements vary widely in their provisions. However, from the standpoint of patient care, there is apparently little difference in the manner that medical care would actually be provided whether or not a leasing arrangement existed.

The lease usually provides for a rental payment that is not representative of the actual costs of the services furnished. Ordinarily, the rental payment closely approximates or exceeds the facility's normal charges. The rental amount may be stated in a variety of ways; the lessor's normal charges; a modification of the standard charges representing a stipulated reduction; a monthly rental per bed plus a supplemental payment for general overhead and the purchase at the predetermined rates of specific services such as meals, laundry, medical supplies, and all the usual ancillary services such as drugs, physical therapy, etc.; and many other variations.

Regardless of the parties' motivations for entering into such an agreement, the result of the transaction is to guarantee the lessor a return on a charge basis for providing facilities and services, whether or not utilized by program beneficiaries, as provided in section 1814(b) of the Act. The total situation must be considered in a determination of reasonableness of the cost base especially where the lessor itself engaged in the operation of a health facility within the same structure leased in part to the provider.

Where leasing arrangements described above exist, the intermediary should notify the appropriate Bureau of Health Insurance Regional Representative (where SNF's are concerned, the Office of Long-Term Care Standards enforcement in the Regional Director's Office) so that he may determine whether the certification of the lessee distinct-part is proper. The provisions of each such lease will be reviewed to determine whether the "lessee-provider" is actually a certifiable skilled nursing facility. Whether or not the institution meets the definitions of a "skilled nursing

facility" in *§1819(j)* of the Act, the full circumstances under which it proposes to provide services to beneficiaries on a reasonable cost basis must be reviewed and weighted by the regional office to assure compliance with the Act. Preferably, this is done before an agreement is entered into. However, the certification ordinarily can only be made based upon the on-going operation in order to assure compliance.

113.2 Reimbursement.--When an entire facility or a skilled nursing care distinct-part has been leased by a provider under an arrangement whereby the lessor operates and furnishes essential services, and the lessee requires payments to the lessor that are not representative of the actual cost of the facilities or services furnished by the lessor, the program does not recognize such payments for reimbursement purposes. The program reimburses the lessee only on the basis of the lessor's reasonable costs of furnishing the services. Generally speaking, this involves two cost finding processes - one for the lessor, which requires a determination of cost attributable to the leased distinct-part of the entire facility, if applicable; and one for the lessee's actual operation. The lessor's costs are determined under the Medicare reimbursement principles except that there are no provisions for (1) owner's compensation, or (2) return on equity capital. However, these times are appropriately recognized in the cost finding procedure for the lessee. In addition, any costs for duplicate identifiable services between the lessor and lessee must be eliminated from the lessor's cost.

114. BASIS FOR DEPRECIATION

A. New Assets.--The basis for depreciation of new assets under the straight-line (see §116.1) and the sum-of-the-years' digits (see §116.2) methods is the historical cost of the asset less its salvage value. For the historical cost of donated assets, see §104.16. Section 116B explains the conditions under which the sum-of-the-years' digits method may be used.

Under the declining balance method (see §116.3), the basis for depreciation is the historical cost only. Sections 116B and C explain the applicability and limitation of the use of the declining balance method.

B. Assets Partially or Fully Depreciated on Provider's Books When Provider Enters Program.--For assets that are fully or partially depreciated on the provider's books when the provider enters the program, the basis for depreciation under the straight-line (see §116.1) and the sum-of-the-years' digits (see §116.2) methods is the adjusted historical cost, as defined below, less the salvage value. Section 116B explains the conditions under which the sum-of-the-years' digits method may be used.

Under the declining balance method (see §116.3), the basis for depreciation is the adjusted historical cost only. Sections 116B and C explain the applicability and limitation of use of the declining balance method.

The adjusted historical cost of an asset that is in use when the provider enters the program is its historical cost reduced by the depreciation accumulated up to the date of entrance into the program. Accumulated depreciation for this purpose may be determined on a straight-line basis (regardless of the depreciation method used or in use by the provider) and based on an estimate of the asset's useful life, taking into account past and current information.

When a provider enters the program, it has an opportunity to revise the useful life of its assets taking into account past and current information, subject

to the approval of the intermediary. For example, if an asset currently in use has been fully depreciated on the provider's books, it would be evident that the asset's useful life has not ended. Consequently, a new estimate of the asset's useful life, based on current information, may be made.

When the useful life of an asset is revised, the adjusted historical cost is based on the historical cost reduced by the revised accumulated depreciation based on the new estimate of the asset's useful life. The revised depreciation may be determined on a straight-line basis regardless of the depreciation method used or in use by the provider. The amount of depreciation on the provider's books is not *to be* considered in the determination.

The following illustrates how the basis for depreciation is determined for used assets when a provider enters the program and revises the useful life of an asset.

FACTS

The provider entered the program on July 1, 1993	
Asset acquired on July l, 1987.	
Original estimated useful life is 8 years.	
Historical cost of the asset	$1,500,000
Estimated salvage value	$100,000
Accumulated depreciation on the provider's books, using the straight line method of depreciation	$1,050,000

When the provider entered the program, it reevaluated the useful life of the asset and estimated that its useful life was 12 years from the date of acquisition. The intermediary approved the change. The basis for depreciation under the program is determined as follows:

Step 1. Determine adjusted historical cost:

Historical cost	$1,500,000
Less estimated salvage value	100,000
Basis for computing revised accumulated deprecation	$1,400,000
Revised accumulated depreciation (6/12 x $1,400,000)	$700,000
Adjusted historical cost:	
Historical cost	$1,500,000
Less revised accumulated depreciation	700,000
Adjusted historical cost	$800,000

Step 2. Determine basis for depreciation under the program:

Using the straight-line method:	
Adjusted historical cost	$800,000
Less estimated salvage value	100,000
Basis for depreciation	$700,000

NOTE: The method of determining the accumulated depreciation and the adjusted historical cost for depreciation under the program is the same, regardless of the method of depreciation previously used by the provider.

114.1 Transfer of Governmental Facilities.--

A. Intergovernmental Transfer of Facilities.--When assets are transferred from one governmental entity to another under appropriate legal authority, the basis for depreciation is determined as follows.

1. Bona Fide Sale.--The basis for depreciation in a bona fide sale is the historical cost subject to the following limitations.

a. For assets acquired by other than hospitals or SNFs after 1970 and before December 1, 1997, or for assets acquired by hospitals or SNFs after 1970 and before July 18, 1984, the historical cost incurred by the present owner in acquiring the asset under a bona fide sale must not exceed the lower of:

(1) The current reproduction cost adjusted for straight-line depreciation over the life of the asset to the time of the purchase; or

(2) Fair market value at the time of the purchase.

b. For assets acquired by hospitals or SNFs on or after July 18, 1984 (see §104.10.C) and before December 1, 1997, the historical cost cannot exceed the lower of:

(1) The allowable acquisition cost, for Medicare purposes, of the asset to the owner of record as of July 18, 1984 (or in the case of an asset not in existence as of July 18, 1984, the first owner of record of the asset after that date);

(2) The acquisition cost of the asset to the new owner; or

(3) The fair market value of the asset on the date of acquisition.

c. For assets acquired by all providers on or after December 1, 1997, the allowable acquisition cost to the acquirer will be the historical cost less depreciation allowed to the owner of record as of August 5, 1997. (See §104.10.E.)

2. Donation.--An asset is considered donated when a governmental entity acquires the asset without assuming the functions for which the transferor used the asset or without making any payment for it in the form of cash, property, or services. To determine the basis for depreciation of a donated asset, see §114.2.

3. If neither items 1 or 2 above applies, i.e., the transfer was solely to facilitate administration or to reallocate jurisdictional responsibility, or the transfer constituted a taking over in whole or in part of the function of one governmental entity by another governmental entity, the basis for depreciation is:

a. For an asset on which the transferor has claimed depreciation under the Medicare program, the transferor's basis under the Medicare program prior to the transfer. The method of depreciation used by the transferee may be the same as that used by the transferor, or the transferee may change the method. (Beginning August 1, 1970, a provider may only change from an accelerated method or optional method to the straight-line method. See §120.)

b. For an asset on which the transferor has not claimed depreciation under the Medicare program, the cost incurred by the transferor in acquiring the asset (not to exceed the basis that would have been recognized had the transferor participated in Medicare program) less depreciation calculated on the straight-line basis over the life of the asset to the time of transfer.

B. Transfer of State Hospital to Nonprofit Corporation Without Monetary Consideration.--If a State transfers a hospital to a nonprofit corporation without monetary consideration on or after July 18, 1984, the depreciable basis of the assets to the new owner is the net book value of the assets as recorded on the State's books at the time of the transfer. For the purpose of this section, monetary consideration includes cash, new debt, and assumed debt.

114.2 Assets Donated to Provider.--Where an asset is donated to a provider as described in §104.16, the basis for depreciation is determined as follows.

1. Assets Not Used or Depreciated Under Medicare Program.--If an asset has never been used or depreciated under the Medicare program and is donated to a provider, the basis for the purpose of calculating depreciation and equity capital (if applicable) is the fair market value of the asset (see §104.15) at the time of donation.

2. Assets Used or Depreciated Under Medicare Program--If an asset has been used or depreciated under the Medicare program and is donated to a provider or when a provider acquires such assets through estate or intestate distribution, e.g., a widow inherits a skilled nursing facility upon the death of her husband and becomes the owner of a newly certified provider, the basis for the purpose of calculating depreciation and equity capital (if applicable) is *the lesser of:*

a. The fair market value at the time of donation; or

b. The net book value in the hands of the owner last participating in the Medicare program.

For donated assets, the basis for depreciation is determined as of the date of donation or the date of death, whichever is applicable. See §104.23 for determining net book value and §104.16 for determining fair market value of donated assets.

When the provider's records do not contain the fair market value of the donated assets as of the date of donation, an appraisal of such fair market value by a recognized appraisal expert is acceptable for depreciation and owner's equity capital purposes.

The provider furnishes its intermediary with information identifying the appraisal expert and type and method of appraisal to be used. The intermediary determines whether the contemplated appraisal is acceptable. *(See §134ff.)*

116. DEPRECIATION METHODS

A. General.--The straight-line method of computing depreciation is acceptable for all depreciable assets. The availability of various methods of accelerated depreciation is dependent upon the date the asset was acquired and other criteria described in paragraphs B and C. Regardless of the method of depreciation being used, an asset should not be depreciated below its salvage value (see § 104.18). The depreciation method used in claiming depreciation on a particular asset for the first time will be presumed to be the depreciation method selected for the asset. A provider need not use the same method for all depreciable property.

B. Depreciation Method Applicable to Acquisition or transaction Before August 1970.--For the following depreciable assets, in addition to the straight-line method of depreciation, a declining balance method (not to exceed double the straight-line rate or the sum of the years' digits method may be used:

1. Depreciable assets for which accelerated depreciation was used for health insurance program purposes prior to August 1970.

2. Depreciable assets for which a timely request to change from straight-line depreciation to accelerated depreciation was received by the intermediary prior to August 1970.

3. Depreciable assets acquired before August 1970, where no election to use straight-line depreciation, accelerated depreciation, or the optional allowance for depreciation was in effect on such date and the provider was participating in the program on such date. An asset is considered acquired as of the date it is within the control of the provider.

4. Depreciable assets of a provider where construction, remodeling, reconstruction, or other capital improvements began prior to February 5, 1970, and the provider ws participating in the program on February 5, 1970. Construction is deemed to begin when physical work is started on the project at the site of the facility. Preliminary work such as planning agency approval, demolition of old buildings, land clearing, feasibility surveys, and architectural drawings are not considered the beginning of construction.

5. Depreciable assets of a provider where a valid written contract was entered into by the provider participating in the program before February 5, 1970, for construction, acquisition, or for the permanent financing thereof and such contract was binding on the provider on February 5, 1970, and at all times thereafter. The contract must identify the asset and specify the cost of the asset. The contract may permit minor modifications in the construction of the asset and in the cost of the asset.

The contract for permanent financing must be for the construction or acquisition of a specific facility or asset. An open-ended commitment by a bank or other institution to furnish funds for the construction or acquisition of a facility or asset is not considered a binding contract for permanent financing.

Approval for financing with Hill-Burton or Hill-Harris program funds or loans insured by the FHA are considered contracts for permanent financing. These loans must have been approved prior to February 5, 1970, and must be designated for the construction or acquisition of a specific facility or asset.

The issuance of bonds to finance the construction or acquisition of a facility or asset is considered a valid contract for permanent financing. the bond issuance must be designated for the construction or acquisition of a specific asset or facility. Final approval of the bond issuance must have occurred prior to February 5, 1970.

C. Depreciable Assets Acquired After July 1970.--For depreciable assets acquired after July 1970 (except for asserts acquired as described in B.4 or B.5 above), a declining balance method not to exceed 150 percent of the straight-line rate may be used where the cash flow from depreciation on the total assets of the institution which are used to provide patient care services during the reporting period, including straight-line depreciation on the assets in question, is insufficient (assuming funding of available capital not required currently for amortization and assuming reasonable interest income on such funds) to supply the funds required to meet the reasonable principal amortization schedules on the capital debits related to the provider's total depreciable assets used to provide patient care services. For each depreciable asset for which a provider submits a written request to use a declining balance method for health insurance reimbursement purposes (not to exceed 150 percent of the straight-line rate), the provider must demonstrate to the intermediary's satisfaction that the required cash flow need exists. For each depreciable asset where a provider justifies the use of accelerated depreciation, the intermediary must give written approval for the use of a depreciation method other than straight line before basing any interim payment on the accelerated depreciation or making a reasonable cost determination for a reporting period which included an allowance for such depreciation.

116.1 Straight-Line Method.--Under this method the annual allowance is determined by dividing the cost of the asset (less any estimated salvage value) by the years of useful life. This method produces a uniform allowance each year. The following examples illustrate how depreciation is computed:

NEW ASSET

Facts: Acquisition	$17,000
Estimated salvage value	2,000
Estimated useful life	5 years
Annual depreciation is computed as follows:	
Acquisition cost	$17,000
Less: Estimated salvage value	2,000
Basis for depreciation	$15,000

Basis for Depreciation / Useful Life = Depreciation per annum

$15,000 / 5 years = $3,000 each year

The annual allowance can also be computed by using a percentage applied to the basis for depreciation. For example, in the above illustration, a 5-year life produces a 20% rate (100%/5 years). This 20% rate, when applied to the $15,000 basis for depreciation, results in an annual $3,000 depreciation allowance for each of the 5 years.

USED ASSET

Facts: Historical cost	$46,000
Salvage value	1,000
Estimated useful life	15 years
Years asset used by provider before entrance into program	10 years
Straight-line method of depreciation to be used for Medicare purposes.	

Annual depreciation is computed as follows:

a. Determine the number of remaining years of useful life (15 years minus 10 years = 5 years of remaining useful life).

b. Determine the basis for depreciation as follows:

Cost		$46,000
Deduct:	Salvage value	1,000
	Balance	$45,000
Deduct:	Accumulated depreciation under the straight-line method for 10 years	
	(10 years x $45,000) / 15 years =	$30,000
	Basis for depreciation	$15,000

c. Divide the basis for depreciation by the number of years of remaining life:

Item b / Item a = $15,000 / 5 years = $3,000 annual depreciation

116.2 Sum-of-the-years' Digit Method.--Under this method, the annual depreciation allowance is computed by multiplying the basis for depreciation (cost less estimated salvage value) by a constantly decreasing fraction. The numerator of the fraction represents the remaining years of useful life of the asset at the beginning of each year, and the denominator represents the sum of the years of estimated useful life at the time of acquisition in case of new assets or at time of entrance into the program in the case of used assets. The following example illustrates how depreciation is computed:

NEW ASSET
Facts: Cost $17,000
Estimated salvage value 2,000
Estimated useful life .....5 years
Depreciation is computed as follows:

a. Add each number in the estimated useful life (5 years: 1+2+3+4+5=15).
b. Use the sum 15 as the denominator of the fraction.
c. Each year, for the numerator of the fraction use the remaining years of useful life including the year for which depreciation is taken. This means using each number in a. above in inverse order (5,4,3,2,1), i.e., 5 for the first year, 4 for the second year, 3 for the third year, etc.
d. Multiply the basis for depreciation by this fraction (c divided by d).

Cost $17,000
Salvage 2,000
Basis for depreciation.....$15,000

Annual Computation

Year	Basis for Depreciation		Ratio	Annual Depreciation Allowance
1st	$15,000	x	5/15 =	$5,000
2nd	$15,000	x	4/15 =	$4,000
3rd	$15,000	x	3/15 =	$3,000

USED ASSET
Facts: Cost $46,000
Salvage value 1,000
Estimated useful life .....15 years
Provider used the asset (prior to entrance into program) for.....10 years
Annual depreciation is computed as follows:

a. Determine the number of remaining years of useful life (15 years minus 10 years = 5 years of remaining useful life).
b. Add each number of the remaining years of useful life (5 years = 1+2+3+4+5=15).
c. Use the sum 15 as the denominator of the fraction.
d. Each year, for the numerator of the fraction, use the remaining years of useful life including the year in which depreciation is taken. This means using each number in b. above in inverse order (5,4,3,2,1,), i.e., 5 for the first year under the program, 4 for the second year under the program, 3 for the third year under the program, etc.

e. Determine the basis for depreciation as follows:

Cost		$46,000
Deduct:	Salvage value	1,000
	Balance	$45,000
Deduct:	Accumulated depreciation under straight-line method for 10 years	
	$45,000 x 10 years / 15 years	$15,000

f. Multiply the basis for depreciation by (e) by the fraction (d divided by c) to determine annual depreciation.

Annual Computation

Year	Basis		Ratio	Annual Depreciation Allowance
1st	$15,000	x	5/15	$5,000
2nd	$15,000	x	4/15	$4,000
3rd	$15,000	x	3/15	$3,000

116.3 Declining Balance Method.--Under this method, the annual allowance is computed by multiplying the undepreciated balance of the historical cost of the asset by a uniform rate up to double the straight-line rate. Where the declining balance method is justified for assets acquired after July 1970, the declining balance rate cannot exceed 150 percent of the straight-line rate. (See section 116.C.) Salvage value is not considered in computing the depreciation allowance. However, under this method, the asset should not be depreciated below the estimated salvage value.

NEW ASSET

Facts: Cost		$17,000
	Salvage value	2,000
	Estimated useful life	5 years
	Rate to be used	Double the straight-line rate: 2 x 20% = 40%.

Annual Depreciation is computed as follows:

Year	Undepreciated Balance		Ratio	Annual Depreciation Allowance
1st	$17,000	x	40% =	$6,800
2nd	10,200	x	40% =	$4,080
3rd	6,120	x	40% =	$2,448

USED ASSETS

Facts:		
	Cost	$46,000
	Salvage value	1,000
	Estimated useful life	15 years
	Provider used the asset (prior to entrance into the program)	10 years
	Double the straight-line rate to be used under the program.	

Annual depreciation is computed as follows:

a. Determine the number of remaining years of useful life. (15 years minus 10 years = 5 years of remaining useful life)

b. Determine the straight-line rate for the remaining years of useful life (100% / 5 yrs. = 20%)

c. Double the straight-line (2 x 20% = 40%).

d. Determine the basis for depreciation as follows:

Cost		$46,000
Deduct:	Salvage value	1,000
	Balance	$45,000
Deduct:	Accumulated depreciation under straight-line method for 10 years	
	$45,000 x 10 years / 15 years	$30,000
	Balance	$15,000
	Salvage value	1,000
	Basis for depreciation (or unrecovered cost in first year under the program)	$16,000

e. Multiply each year's undepreciated balance (or unrecovered cost) by 40% (Note: Do not depreciate the asset below its salvage values).

Year	Undepreciated Balance		Ratio	Annual Allowance Depreciation
1st	$16,000	X	40%	$5,400
2nd	$ 9,600	X	40%	$3,840
3rd	$ 5,760	X	40%	$2,304
4th	$ 3,456	X	40%	$1,382
5th	$ 2,074	X	40%	$ 830

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Exhibit Two

Startup Costs

2132.1 General.--In the period of developing a provider's ability to furnish patient care services, certain costs are incurred. The costs incurred during this time of preparation are referred to as start-up costs. Since these costs are related to patient care services rendered after the time of preparation, they must be capitalized as deferred charges and amortized over a number of benefiting periods.

Start-up costs include, for example, administrative and nursing salaries; heat, gas, and electricity; taxes; insurance; mortgage and other interest; employee training costs; repairs and maintenance; housekeeping; and any other allowable costs incident to the start-up period. However, any costs that are properly identifiable as organization costs or capitalizable as construction costs must be appropriately classified as such and excluded from start-up costs.

Where a provider prepares all portions of its facility for patient care services at the same time and has capitalized start-up costs, the start-up costs must be **amortized ratably over a period of 60 consecutive months beginning with the month in which the first patient is admitted for treatment.**

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2130. LIFE INSURANCE PREMIUMS

In general, premiums related to insurance on the lives of owner(s), officer(s), key employee(s) and provider-based physician(s) where the provider is a direct or indirect beneficiary are not allowable costs. A provider is a direct beneficiary where, upon the death of the insured individual, the insurance proceeds are payable directly to the provider. A provider is an indirect beneficiary when another party receives the proceeds of a policy through an assignment by the provider to the party or other legal mechanism but the provider benefits from the payment of the proceeds to the third party.

An exception to these requirements is permitted where (1) a provider as a requirement of a lending institution must purchase insurance on the life of an owner(s), officer(s), key employee(s) or provider-based physician(s) to guarantee the outstanding loan balance (2) the lending institution must be designated as the beneficiary of the insurance policy, and (3) upon the death of the insured, the proceeds will be used to pay off the balance of the loan. The insurance premiums allowable are limited to premiums equivalent to that of a decreasing term life insurance policy needed to pay off the outstanding loan balance. In addition, the loan must be related to patient care and meet the necessary and proper requirements of section 200ff, Interest Expense. Where other than decreasing term policies are purchased (e.g., whole life, or convertible term), only that portion of the premium which can be equated to the premium for a similar face amount of a decreasing term life policy may be included in allowable costs.

The life insurance premiums allowable are reimbursable for cost reporting periods beginning on or after April 15, 1983.

Premiums related to insurance on the lives of owner(s), key employee(s) and provider-based physician(s) where the individual relative(s) or his/her estate is the beneficiary are considered to be compensation to the individual and are allowable costs to the extent such total compensation is reasonable.

2132. START-UP COSTS

2132.1 General.--In the period of developing a provider's ability to furnish patient care services, certain costs are incurred. The costs incurred during this time of preparation are referred to as start-up costs. Since these costs are related to patient care services rendered after the time of preparation, they must be capitalized as deferred charges and amortized over a number of benefiting periods.

Start-up costs include, for example, administrative and nursing salaries; heat, gas, and electricity; taxes; insurance; mortgage and other interest; employee training costs; repairs and maintenance; housekeeping; and any other allowable costs incident to the start-up period. However, any costs that are properly identifiable as organization costs or capitalizable as construction costs must be appropriately classified as such and excluded from start-up costs.

Amortized start-up costs may be charged only to the "Administrative and General" cost center unless these costs can be specifically identified with a cost center or component of a provider, in which case the amortized costs must be directly assigned to the applicable cost center or component.

Unless otherwise specified herein, the provisions of this section are effective for providers after June 30, 1976.

2132.2 Applicability--Start-up costs are incurred from the time preparation begins on a newly constructed or purchased building, wing, floor, unit, or expansion thereof to the time the first patient, whether Medicare or non-Medicare, is admitted for treatment, or, where the start-up costs apply only to nonrevenue-producing patient care functions or non-allowable functions, to the time the areas are used for their intended purposes. If a provider intends to prepare all portions of its entire facility at the same time, start-up costs for all portions of the facility should be accumulated in a single deferred charge account and should be amortized when the first patient is admitted for treatment. However, if a provider intends to prepare portions of its facility on a piecemeal basis (i.e., preparation of a floor or wing of a provider's facility is delayed), start-up costs should be capitalized and amortized separately for the portion(s) of the provider's facility prepared during different time periods. Moreover, if a provider expands its facility by constructing or purchasing additional buildings or wings, start-up costs should be capitalized and amortized separately for these areas.

Start-up costs that are incurred immediately before a provider enters the program and that are determined to be immaterial by the intermediary need not be capitalized, but rather, may be charged to operations in the first cost reporting period. In the case where a provider incurs start-up costs while in the program and these costs are determined to be immaterial by the intermediary, these costs need not be capitalized, but may be charged to operations in the periods incurred.

For program reimbursement purposes, costs of the provider's facility and building equipment should be depreciated over the lives of these assets starting with the month the first patient is admitted for treatment, subject to the provider's method of determining depreciation in the year of acquisition or construction (see §118). Where portions of the provider's facility are prepared for patient care services after the initial start-up period, these asset costs applicable to each portion should be depreciated over the remaining lives of the applicable assets. If the portion of the facility is a patient care area, depreciation should start with the month the first patient is admitted for treatment. If the portion of the facility is a nonrevenue-producing patient care area or nonallowable area, depreciation should begin when the area is opened for its intended purpose. Costs of major movable equipment, however, should be depreciated over the useful life of each item starting with the month the item is placed into operation, subject to §118.

2132.3 Cost Treatment for Medicare Reimbursement.--

A. Operations Begin Upon Entrance into the Program (Providers Entering Program After June 30, 1976).--

1. Where a provider prepares all portions of its facility for patient care services at the same time and has capitalized start-up costs, the start-up costs must be amortized ratably over a period of 60 consecutive months beginning with the month in which the first patient is admitted for treatment.

2. Where a provider prepares portions of its facility for patient care services on a piecemeal basis, start-up costs must be capitalized and amortized separately for the portions of the provider's facility that are prepared for patient care services during different periods of time.

EXAMPLE:

Facts: On July 1, 1976, the provider entered the program with a new three-floor facility. The first two floors of the facility were prepared and available for patient care services at the time the provider entered the program; however, preparation of the third floor for patient care services was deferred until July 1, 1977. The first patient was admitted to the first two floors on July 5, 1976, while the first patient was admitted to the third floor on October 15, 1977. Start-up costs of $60,000 were capitalized for the first two floors from the time preparation began on these floors for the rendition of patient care services to July 5, 1976. Start-up costs of $25,000 were also capitalized for the third floor from July 1, 1977 to October 15, 1977.

With the above facts, the provider would accumulate the start-up costs of $60,000 attributable to the first two floors separately from the start-up costs of $25,000 attributable to the third floor. The start-up costs of $60,000 would be amortized at the rate of $1,000 per month beginning in July 1976 and ending 1981. The start-up costs of $25,000 attributable to the third floor would be amortized at the rate of $417 per month from October 1977 to September 1982.

B. Operations Begin Prior to Entrance into the Program (Providers Entering Program After June 30, 1976).--Where a provider enters the program more than 60 months after its first patient is admitted for treatment, start-up costs unamortized at the time the provider enters the program will not be allowable. However, where a provider enters the program within 60 months after its first patient is admitted for treatment and has capitalized start-up costs, the portion of start-up costs unamortized at the time the provider enters the program may be included in allowable costs using a 60-month amortization period starting with the month the provider admitted its first patient for treatment. In these situations, if a provider chooses to include amortized start-up costs in its allowable costs, the costs must be recomputed as follows:

EXAMPLE 1:

Facts: A provider enters the program on July 1, 1976, 30 months after it admitted its first patient; start-up costs were capitalized in the amount of $30,000; and amortization is based on a 120-month period.

	Per Books	Medicare
Original amount of start-up costs to be amortized	$30,000	$30,000
Amount amortized as of July 1, 1976		
(30/120 x $30,000)	$ 7,500	
Unamortized start-up costs as of July 1, 1976	$22,500	
Amount which would have been amortized over 60 months		
(30/60 x 30,000)		$15,000
Amount to be amortized under the program over a 30-month period		$15,000

EXAMPLE 2:

Facts: A provider enters the program on July 1, 1976, 24 months after it admitted its first patient; start-up costs were capitalized in the amount of $36,000; and amortization is based on a 36-month period.

Original amount of start-up costs to be amortized	$36,000	$36,000
Amount amortized as of July 1, 1976		
(24/36 x 36,000)	$24,000	
Unamortized start-up costs as of July 1, 1976	$12,000	
Amount which would have been amortized over 60 months		
(24/60 x 36,000)		$14,400
Amount to be amortized under the program over a 36-month period		$21,600

If a provider enters the program within 60 months after admitting its first patient for treatment, start-up costs may be capitalized retroactively (reduced for any periods already elapsed from the time the first patient was admitted for treatment) where the provider did not initially capitalize start-up costs (or has written off such costs in the period(s) incurred) before entering the program and the provider can establish these costs to the satisfaction of the intermediary.

C. Providers Entering Program Before July 1, 1976.--Where a provider enters the program before July 1, 1976, and capitalizes start-up costs incurred before July 1, 1976, the provider may continue to amortize the start-up costs ratably over a period of up to 60 consecutive months, but not less than 36 consecutive months, beginning with the month the first patient is admitted for treatment or, in the case of a nonrevenue-producing patient care area or nonallowable area, beginning with the month the area is opened for its intended purpose. Where a provider enters the program before July 1, 1976, and incurs start-up costs after June 30, 1976, start-up costs must be treated in the manner described in §2132.3A. Start-up costs that are considered to be immaterial by the intermediary may be included in allowable costs in the cost reporting period(s) incurred.

2132.4 Sale of Institution.--Where a provider institution is sold before the expiration of the amortization period, the portion of start-up costs amortizable through the month of sale is includable in allowable costs. If the unamortized balance of start-up costs at the time of sale represents a value reflected in the selling price to the purchaser and contained in the sales agreement, this value will be limited to the lesser of the sales price attributed to the start-up costs or the unamortized balance of start-up costs on the books of the seller. If the purchaser becomes a provider, the unamortized start-up costs subject to the above limitation (reduced for any period in which the purchaser operates the facility before becoming a provider, unless this period is represented by a delay in certification caused by the program) transferred in the sale may be amortized and included in allowable costs over the remaining portion of the period established for amortization by the seller-provider. If the unamortized balance of the start-up costs at the time of sale is not identified in the sales price (the sales agreement does not allocate a portion of the sales price to this unamortized balance), the seller-provider may include the unamortized costs in its allowable costs for the last cost report submitted to the program.

2132.5 Withdrawal from Program.--Where a provider withdraws from the program, start-up costs amortizable through the month of withdrawal are includable in allowable costs. Unamortized start-up costs adjusted through the month of withdrawal are applicable to services provided after the month of withdrawal and, therefore, are not includable in allowable costs. However, where the provider ceases to provide health care services on withdrawal from the program, the unamortized costs at termination may be included in the provider's allowable costs for the last cost report submitted to the program.

2132.6 Effect on Equity Capital.--Unamortized start-up costs allowable for program purposes are includable in the equity capital of a provider.

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Exhibit Three

Organization Costs

2134.l Organization Costs--General.--Organization costs are those costs directly incident to the creation of a corporation or other form of business. These costs are an intangible asset in that they represent expenditures for rights and privileges which have a value to the enterprise. The services inherent in organization costs extend over more than one accounting period and thus affect the cost of future periods of operation.

A. Allowable Organization Costs.--Allowable organization costs include, but are not limited to, legal fees incurred in establishing the corporation or other organization (such as drafting the corporate charter and by-laws, legal agreements, minutes of organizational meeting, terms of original stock certificates), necessary accounting fees, expenses of temporary directors and organizational meetings of directors and stockholders, and fees paid to States for incorporation.

B. Unallowable Organization Costs.--The following types of costs are not considered allowable organization costs: costs relating to the issuance and sale of shares of capital stock or other securities, such as underwriters' fees and commissions, accountant's or lawyer's fees, cost of qualifying the issues with the appropriate State or Federal Authorities, stamp taxes, etc.

Unless specified otherwise herein, the provisions of this section are effective for providers after June 30, l976.

2134.2 Cost Treatment of Organization Costs under Medicare--.

A. Providers Entering Program After June 30, l976.--Allowable organization costs should generally be capitalized by the organization. However, if in the opinion of the intermediary, these costs are not material when compared to total allowable costs, they may be included in allowable costs for the initial cost reporting period. **Otherwise, allowable organization costs are amortized ratably over a period of 60 months starting with the month the first patient is admitted for treatment.**

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2134. ORGANIZATION AND OTHER CORPORATE COSTS

2134.1 Organization Costs--General.--Organization costs are those costs directly incident to the creation of a corporation or other form of business. These costs are an intangible asset in that they represent expenditures for rights and privileges which have a value to the enterprise. The services inherent in organization costs extend over more than one accounting period and thus affect the cost of future periods of operation.

A. Allowable Organization Costs.--Allowable organization costs include, but are not limited to, legal fees incurred in establishing the corporation or other organization (such as drafting the corporate charter and by-laws, legal agreements, minutes of organizational meeting, terms of original stock certificates), necessary accounting fees, expenses of temporary directors and organizational meetings of directors and stockholders, and fees paid to States for incorporation.

B. Unallowable Organization Costs.--The following types of costs are not considered allowable organization costs: costs relating to the issuance and sale of shares of capital stock or other securities, such as underwriters' fees and commissions, accountant's or lawyer's fees, cost of qualifying the issues with the appropriate State or Federal Authorities, stamp taxes, etc.

Unless specified otherwise herein, the provisions of this section are effective for providers after June 30, 1976.

2134.2 Cost Treatment of Organization Costs under Medicare--.

A. Providers Entering Program After June 30, 1976.--Allowable organization costs should generally be capitalized by the organization. However, if in the opinion of the intermediary, these costs are not material when compared to total allowable costs, they may be included in allowable costs for the initial cost reporting period. Otherwise, allowable organization costs are amortized ratably over a period of 60 months starting with the month the first patient is admitted for treatment.

If the provider enters the program after 60 months, starting with the month the first patient is admitted for treatment, no organization costs are recognized. Organization costs can be capitalized retroactively (reduced for any periods already elapsed from the time the first patient was admitted for treatment) where a provider (1) did not initially capitalize organization costs (or has written off such costs in the period(s) incurred) before entering the program; (2) can establish these costs to the satisfaction of the intermediary; and (3) enters the program within 60 months after the first patient was admitted for treatment.

B. Providers Entering Program Before July 1, 1976.--Where a provider enters the program before July 1, 1976, and capitalizes organization costs, the provider may continue to amortize the organization costs ratably over a period of 60 consecutive months beginning with the date of organization. However, if the organization costs were considered to be immaterial by the intermediary, the costs may be included in the provider's allowable costs in the cost reporting period(s) incurred.

2134.3 Amortization Period of 60 Months.--Where a provider is newly organized upon entering the program and has capitalized organization costs, these costs must be amortized ratably over a 60-month period starting with the month the first patient is admitted for treatment. Where a provider admitted its first patient for treatment within a 60-month period prior to entry into the program and has capitalized organization costs using a 60-month amortization period, no change in the rate of amortization is permitted. In this instance, the unamortized portion of organization costs is allowable under the program and is amortized over the remaining part of the 60-month period.

2134.4 Amortization Period Less Than 60 Months.--Where a provider has entered the program within 60 months after the first patient is admitted for treatment, has capitalized organization costs, but has used an amortization period of less than 60 months, an adjustment will be necessary if the provider chooses to include amortized organization costs in its allowable costs. The unamortized amount of organization costs must be recomputed using a 60-month period starting with the month the first patient is admitted for treatment. The recomputed unamortized portion of organization costs as of the month the provider enters the program is recognized as an asset under the program and may be amortized over the remaining months of the 60-month period.

EXAMPLE: A provider enters the program 24 months after the first patient is admitted for treatment; organization costs were capitalized in the amount of $12,000; amortization is based on a 36-month period.

	Per Books	Medicare
Organization costs to be amortized	$12,000	$12,000
Amount amortized to date ($\frac{24}{36}$ x $12,000)	8,000	
Book balance unamortized as of date of entry into program	4,000	

	Per Books	Medicare
Amount which would have been amortized on a 60-month basis		
($\frac{24}{60}$ x $12,000)		4,800
Total amount to be amortized under the program		$ 7,200

2134.5 Amortization Period Greater Than 60 Months.--Where a provider has entered the program within 60 months after the month the first patient is admitted for treatment, has capitalized organization costs, but used an amortization period longer than 60 months, an adjustment will be necessary if the provider chooses to include amortized organization costs in its allowable costs. The unamortized amount of organization costs must be recomputed as of the date of entry into the program using a 60-month period starting with the month the first patient was admitted for treatment. The unamortized amount so computed will be recognized for program purposes and may be amortized over the remaining part of the 60-month period.

EXAMPLE: A provider enters the program 36 months after the first patient is admitted for treatment; organization costs were capitalized in the amount of $10,000; amortization is based on a 120-month period.

	Per Books	Medicare
Organization costs to be amortized	$10,000	$10,000
Amount amortized to date		
($\frac{36}{120}$ x $10,000)	3,000	
Book balance unamortized as of date of entry into program	$ 7,000	
Amount which would have been amortized on a 60-month basis		
($\frac{36}{60}$ x $10,000)		6,000
Total amount to be amortized under the program		$ 4,000

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Exhibit Four

Accrued Expenses

§ 413.100 Special treatment of certain accrued costs.

(a)*Principle.* As described in § 413.24(b)(2), under the accrual basis of accounting, revenue is reported in the period in which it is earned and expenses are reported in the period in which they are incurred. In the case of accrued costs described in this section, for Medicarepayment purposes the costs are allowable in the year in which the costs are accrued and claimed for Medicarepayment only under the conditions set forth in paragraph (c) of this section.

(b)*Definitions* -

(1)*All-inclusive paid days off benefit.* An all-inclusive paid days off benefit replaces other vacation and sick pay plans. It is a formal plan under which, based on actual hours worked, all employees accrue vested leave or payment in lieu of vested leave for any combination of types of leave, such as illness, medical appointments, holidays, and vacations.

(2)*Self-insurance.* Self-insurance is a means by which a provider independently or as part of a group undertakes the risk of protecting itself against anticipated liabilities by providing funds in an amount equal to anticipated liabilities, rather than by purchasing insurance coverage.

(c)*Recognition of accrued costs* -

(1)*General.* Although Medicare recognizes, in the year of accrual, the accrual of costs for which a provider has not actually expended funds during the current cost reporting period, for purposes of paymentMedicare does not recognize the accrual of costs unless the related liabilities are liquidated timely.

(2)*Requirements for liquidation of liabilities.* For accrued costs to be recognized for Medicarepayment in the year of the accrual, the requirements set forth below must be met with respect to the

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liquidation of related liabilities. If liquidation does not meet these requirements, the cost is disallowed, generally in the year of accrual, except as specified in paragraph (c)(2)(ii) of this section.

(i)*A short-term liability.*

(A) Except as provided in paragraph (c)(2)(i)(B) of this section, a short-term liability, including the current portion of a long-term liability (for example, mortgage interest payments due to be paid in the current year), must be liquidated within 1 year after the end of the cost reporting period in which the liability is incurred.

(B) If, within the 1-year time limit, the provider furnishes to the contractor sufficient written justification (based upon documented evidence) for nonpayment of the liability , the contractor may grant an extension for good cause. The extension may not exceed 3 years beyond the end of the cost reporting year in which the liability was incurred.

(ii)*Vacation pay and all-inclusive paid days off.*

(A) If the provider's vacation policy, or its policy for all-inclusive paid days off, is consistent for all employees, liquidation of the liability must be made within the period provided for by that policy.

(B) If the provider's vacation policy, or its policy for all-inclusive paid days off, is not consistent for all employees, liquidation of the liability must be made within 2 years after the close of the cost reporting period in which the liability is accrued.

(C) If payment is not made within the required time period or if benefits are forfeited by the employee, an adjustment to disallow the accrued cost is made in the current period (that is, the latest year in which payment should have been made or the year in which the benefits are forfeited) rather than in the period in which the cost was accrued and claimed for Medicare payment. However, an contractor may choose to require the adjustment in the period in which the cost was accrued and claimed for Medicarepayment if the cost report for that period is open or can be reopened as provided in § 405.1885 of

this chapter, and if the contractor believes the adjustment is more appropriate in that period.

(iii)*Sick pay.*

(A) If sick leave is vested and funded in a deferred compensation plan, liabilities related to the contributions to the fund must be liquidated, generally within 1 year after the end of the cost reporting period in which the liability is incurred. If, within the 1-year time limit, the provider furnishes to the contractor sufficient written justification (based upon documented evidence) for nonpayment of the liability, the contractor may grant an extension for good cause. The extension may not exceed 3 years beyond the end of the cost reporting year in which the liability was incurred. Contributions to the deferred compensation plan must be reduced to reflect estimated forfeitures. Actual forfeitures above or below estimated forfeitures must be used to adjust annual contributions to the fund.

(B) If the sick leave plan grants employees the nonforfeitable right to demand cash payment for unused sick leave at the end of each year, sick pay is includable in allowable costs, without funding, in the cost reporting period in which it is earned.

(C) Sick pay paid on any basis other than that specified in paragraphs (c)(2)(iii) (A) or (B) of this section can be claimed for Medicarepayment only on a cash basis for the year in which the benefits are paid.

(iv)*Compensation of owners.* Accrued liability related to compensation of owners other than sole proprietors and partners must be liquidated within 75 days after the close of the cost reporting period in which the liability occurs.

(v)*Nonpaid workers.* Obligations incurred under a legally-enforceable agreement to remunerate an organization of nonpaid workers must be discharged no later than the end of the provider's cost reporting period following the period in which the services were furnished.

(vi)*FICA and other payroll taxes - (A) General rule.* The provider's share of FICA and other payroll taxes that the provider becomes

obligated to remit to governmental agencies is included in allowable costs only during the cost reporting period in which payment (upon which the payroll taxes are based) is actually made to the employee. For example, payroll taxes applicable to vacation benefits are not to be accrued in the period in which the vacation benefits themselves are accrued but rather are allowable only in the period in which the employee takes the vacation.

(B)*Exception.* If payment would be made to an employee during a cost reporting period but for the fact the regularly scheduled payment date is after the end of the period, costs of accrued payroll taxes related to the portion of payroll accrued through the end of the period, but paid to the employee after the beginning of the new period, are allowable costs in the year of accrual, subject to the liquidation requirements specified in paragraph (c)(2)(i) of this section.

(vii)*Deferred compensation.*

(A) Reasonable provider payments made under unfunded deferred compensation plans are included in allowable costs only during the cost reporting period in which actual payment is made to the participating employee.

(B) Accrued liability related to contributions to a funded deferred compensation plan must be liquidated within 1 year after the end of the cost reporting period in which the liability is incurred. An extension, not to exceed 3 years beyond the end of the cost reporting year in which the liability was incurred, may be granted by the contractor for good cause if the provider, within the 1-year time limit, furnishes to the contractor sufficient written justification for non-payment of the liability.

(C) Postretirement benefit plans (including those addressed in Statement of Financial Accounting Standards No. 106 (December 1990)) are deferred compensation arrangements and thus are subject to the provisions of this section regarding deferred compensation and to applicable program instructions for determining Medicarepayment for deferred compensation.

(D) Exception: Qualified defined benefit pension plans, which are funded deferred compensation arrangements, shall be reported on a cash accounting basis as follows:

(1) The allowable pension cost shall be equal to the amount of actual pension contributions funded during the hospital's current Medicare cost reporting period, plus any contributions funded in a prior period and carried forward, subject to the limit under paragraph (c)(2)(vii)(D)*(2)* of this section.

(2) Except as provided in paragraph (c)(2)(vii)(D)*(3)* of this section, the allowable pension cost shall not exceed 150 percent of the average contribution(s) funded during the three consecutive Medicare cost reporting periods that produce the highest average contribution(s), out of the five most recent Medicare cost reporting periods (ending with the current cost reporting period). Contributions in excess of the limit may be carried forward to future period(s). In the case of a newly adopted pension plan, the 5-year look-back period and/or the 3-year averaging period will be limited to the number of cost reporting periods the provider sponsored a qualified defined benefit pension plan.

(3) A waiver of the limit imposed under paragraph (c)(2)(vii)(D)(*2*) of this section may be granted for a specific Medicare cost reporting period for all or a portion of the contributions in excess of the limit imposed under paragraph (c)(2)(vii)(D)(*2*) of this section if it is determined that such excess costs are reasonable and necessary for that period.

(viii)*Self-insurance.* Accrued liability related to contributions to a self-insurance program that are systematically made to a funding agency and that cover malpractice and comprehensive general liability, unemployment compensation, workers' compensation insurance losses, or employee health benefits, must be liquidated within 75 days after the close of the cost reporting period.

[60 FR 33136, June 27, 1995, as amended at 64 FR 51909, Sept. 27, 1999; 77 FR 53682, Aug. 31, 2012]

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Exhibit Five

Physician Compensation

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Medicare

Provider Reimbursement Manual Part 1, Chapter 9, Compensation of Owners

Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)

Transmittal 474 **Date: July 21, 2017**

HEADER SECTION NUMBERS	PAGES TO INSERT	PAGES TO DELETE
Table of Contents	9-1 - 9-2 (2pp.)	9-1 - 9-2 (2 pp.)
901 - 906.4	9-3 - 9-10 (8 pp.)	9-3 - 9-8 (6 pp.)

CLARIFIED/UPDATED MATERIAL--*EFFECTIVE DATE:* The inflation factors in section 905.6 are applied on a calendar year basis. The guidelines in section 905.7 are provided beginning with cost reporting periods beginning in Federal Year (FY) 2009.

Section 905.6, Inflation Factor, provides for calendar year (CY) inflation factors to update previous years' reasonable compensation ranges. The factor is from the cost category Professional Fees: Labor Related in the CMS Prospective Payment System Hospital Input Price Index. The data in the Input Price Index is taken from actual data for the most recent year from the Employment Cost Index (ECI) for Professional and Related Services published by the Bureau of Labor Statistics. The data for years prior to 2006 was from the ECI for Professional and Technical Workers. In this transmittal, the factor for CY 2015 has been added and the factor for CY 2005 has been deleted. The factors are applied on a calendar year basis.

Section 905.7, Guidelines for Physician Owner Compensation for Rural Health Clinics, provides guidance in evaluating the reasonable cost of physician owner compensation for rural health clinics. The factors are applied on a calendar year basis. The Physician Owner Compensation Reasonable Cost Guidelines for Rural Health Clinics table provides ranges, by year, for FY 2009 through FY 2014.

DISCLAIMER: The revision date and transmittal number apply to the red italicized material only. Any other material was previously published and remains unchanged.

Chapter 9

COMPENSATION OF OWNERS

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900. PRINCIPLE

A reasonable allowance of compensation for services of owners is an allowable cost, provided the services are actually performed in a necessary function (42 CFR 413.102).

901. APPLICATION

The allowance of compensation for services of sole proprietors and partners is the reasonable value of the services furnished. The test of reasonableness applies to the actual compensation of all individuals performing services in connection with the operation of a provider including: (1) employees, officers, and directors owning stock in closely-held corporations; (2) employees, officers, and directors with a substantial ownership or equity in public corporations; and (3) certain employees of trusts. (See §902.6).

902. DEFINITIONS

902.1 Compensation-Sole Proprietorships and Partnerships.--The allowance of compensation for services of sole proprietors and partners is the amount determined to be the reasonable value of the services furnished regardless of whether there is an actual distribution of the profits of the business or payment made to the sole proprietor/partner. (See §907.)

902.2 Compensation-Corporations.--For purposes of determining whether the total compensation paid to an owner is reasonable, compensation as defined herein means remuneration paid to an owner regardless of the form in which it is paid. (See §§906 and 906.1.) Compensation may be included in allowable provider cost only to the extent that it represents reasonable remuneration for managerial, administrative, professional, and other services related to the operation of the facility and furnished in connection with patient care. Services furnished in connection with patient care include both direct and indirect activities in the provision and supervision of patient care, such as administration, management, and supervision of the overall institution. Costs of activities not related to either direct or indirect patient care, e.g., those primarily for the purpose of managing or improving the owner's financial investment, are not recognized as an allowable cost. Compensation of a physician owner of a facility is subject to an allocation between professional and provider components. (See §2108 and §2182.)

Payments found to represent a return on equity capital are not compensation and are in no event allowable as an item of reimbursable cost. Nor are such payments considered as compensation for purposes of determining the reasonable level of reimbursement of the owner.

902.3 Reasonableness.--Reasonableness requires that the compensation allowance be such an amount as would ordinarily be paid for comparable services by comparable institutions depending upon the facts and circumstances of each case. Reasonable compensation is limited to the fair market value of services rendered by the owner in connection with patient care. Fair market value is the value determined by the supply and demand factors of the open market.

902.4 Necessary.--Necessary means that had the owner not furnished the services, the institution would have had to employ another person to perform those services. The services must be pertinent to the sound conduct and operation of the institution.

902.5 Persons Related to Owner.--Compensation paid to an employee who is an immediate relative of the owner of the facility is also reviewable under the test of reasonableness. For this purpose, the following persons are considered immediate relatives: (1) husband and wife; (2) natural parent, child, and sibling; (3) adopted child and adoptive parent; (4) stepparent, stepchild, stepbrother, and stepsister; (5) father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, and sister-in-law; and, (6) grandparent and grandchild.

902.6 Trusts.--Where a trust operates an institution or has an interest in the corporation or partnership operating the facility, the compensation of an employee who is the settlor or grantor of the trust, a trustee, or a beneficiary of the trust, is subject to the test of reasonableness.

902.7 Compensation for Persons Related to Owner.--The actual compensation to an immediate relative of an owner (as described in §902.5) is subject to the test of reasonableness. No cost may be imputed for the value of these services.

902.8 Proprietary Provider.--A proprietary provider is a provider organized and operated with the expectation of earning a profit for the owners (as distinguished from a provider organized and operated on a nonprofit basis).

904. CRITERIA FOR DETERMINING REASONABLE COMPENSATION-GENERAL

In general, the determination as to the reasonableness of a person's compensation is made by comparing it with the compensation paid to other individuals in similar circumstances. To obtain uniformity in application of the principle, the contractor (1) identifies compensation paid to individuals other than owners by comparable institutions in the same geographical *area, and* (*2*) applies a set of criteria based on the qualifications and responsibilities of the owner to determine his placement within the range.

In establishing the ranges, abnormally low amounts of compensation sometimes received by employees of religiously sponsored providers may be ignored since circumstances led to the establishment of their rate of pay which are not applicable to other persons. Although contractors are to be guided by the established ranges in evaluating the reasonableness of owner compensation, there may be special circumstances where a contractor, on the basis of its judgment, allows an amount that is outside the established range. This might occur where the provider has certain characteristics or the owner has special qualifications and experience which would make a comparison with other institutions and individuals unrealistic.

904.1 Factors to be Considered in Determining Comparability of Institutions.--There are a number of factors involved in the determination of the comparability of institutions which include, but are not necessarily limited to, the following:

A. The Size of an Institution.--The size of institutions will generally be measured by the number of beds; however, because of differences in occupancy rates, in some situations the number of patient days for the period in question may also be used in determining whether particular providers are comparable in size. Where only a portion of the total beds of an institution are certified, the provider should be classified by the total beds available since the compensation paid administrators is based on services rendered to the entire facility. Only a portion of the allowed compensation would be allocated to the certified part of the institution. For home health agencies, size will be measured by the number of visits.

B. Classification of Institutions.--Institutions should be classified by the type and range of services offered. The type of services has reference to the nature of the services rendered; i.e., medical, surgical, rehabilitative, etc. The range of the services means the extent to which the particular kind of service can be rendered. For example, for rehabilitative services, the range of services refers to the amount and kind of physical therapy available, whether speech therapy is available, etc. In considering the type and range of services rendered, emphasis will be given to those services available in the institution rather than services which are available only when arranged for with other organizations by the provider.

C. Number and Types of Personnel Employed.--This factor refers to the number of personnel employed in the various professional and nonprofessional categories.

D. Geographical Location.--In determining the comparability of facilities, geographical location is a consideration. Since consideration is given to the area in which the institution is located and whether it is in an urban, suburban, or rural setting, differences in prevailing living and wage costs are recognized.

904.2 Factors to be Applied in Evaluating Compensation Within Range for Comparable Institutions.--The factors that are considered in determining the reasonableness of owner compensation within the range established for a class of institution include the following:

A. The qualifications of the owner, including *the owner's* educational attainment and experience in similar responsible positions. Education and experience are pertinent only as they relate to the job being performed and services being rendered. Where an owner-administrator is also a physician, the services evaluated are administrative in nature rather than the actual practice of medicine. Therefore, the compensation allowed is based on the compensation nonphysician administrators receive rather than on the rate physicians receive for their professional services.

B. The number and types of professional and other personnel supervised by the owner.

C. The duties and responsibilities of the owner and the actual services rendered.

1. Information as to the owner's actual duties, responsibilities, hours, and days regularly worked, etc., should be obtained. Compensation for full-time service requires that at least 40 hours per week be devoted to the duties of the position for which compensation is required. Owners devoting less than 40 hours per week to the position will be compensated on a proportionate basis, with 40 hours per week considered to be the full-time *for* such proportionate compensation.

2. The fact that an owner may have potential supervisory and managerial authority *as well as* responsibility for an institution is not as important as the manner in which authority and responsibility is actually exercised. For example, another individual, perhaps with the designation of assistant administrator, might perform most day-to-day managerial and supervisory functions in an institution. In such case, the right of the owner-administrator to overrule decisions does not constitute a basis for recognition of compensation comparable to administrators in other similar institutions.

D. Whether the owner performs services for any other institutions or is engaged in any other occupation.

1. *When* an owner performs services for several institutions, *the owner presumably* spends less than full time (i.e., at least less 40 hours a week) with each institution. In such cases, allowable compensation shall reflect an amount proportionate to a full-time basis.

2. If an owner is engaged in another activity, such as an owner-administrator also having a private medical practice, *the owner* ordinarily could not render full-time services as administrator of the institution.

905. PROCEDURES FOR DETERMINING REASONABLE COMPENSATION

905.1 General.--Contractors have the responsibility for evaluating the reasonableness of owner compensation in terms of the criteria provided in §§904.1 and 904.2. On the basis of information obtained by surveys of providers, *the contractors establish* ranges of compensation for comparable institutions. Contractors will utilize these ranges both for final settlement and when setting interim rates.

Where an owner indicates *they* function in an executive role other than as administrator (e.g., president, executive director, etc.), the contractor will ascertain the owner's actual duties and categorize by the nature of the services rendered in connection with patient care rather than by the various titles administrators might have. Contractors will consolidate virtually identical or similar services to permit the establishment of realistic ranges.

Where an owner occupies a position other than as administrator (e.g., nursing supervisor), the determination of the reasonableness of the compensation may be much simpler since there would tend to be more uniformity in the type of service rendered in a position other than as an administrator.

905.2 Surveys.--Surveys shall include all proprietary institutions and a sufficient number of comparable nonproprietary institutions in the same geographical area so that an adequate comparison can be made. The comparison should take into consideration the services compensation of non-owner administrators of proprietary and nonproprietary facilities.

905.3 Uniform Approach.--The application of this policy requires a consistency in the development of ranges of compensation for services in comparable situations. To insure that this consistency is achieved, the regional offices have the responsibility for coordinating contractor activities.

There may be situations in which an individual has an ownership interest in providers serviced by different contractors. It is appropriate for contractors to inquire of the owner whether such situation does exist and, if so, to coordinate its determination with the other contractor(s).

905.4 New Providers and Future Surveys.--*When* a proprietary provider first enters the program, the owner compensation is evaluated by its contractor in terms of the ranges of compensation established for comparable institutions. After a period of *time, contractors may need* to resurvey their providers because of changes in compensation levels and changes in the duties and responsibilities of the owners.

905.5 Few Similar Providers in an Area.--Where there are few comparable institutions in an area, it may be difficult for a contractor to evaluate the reasonableness of an owner's compensation. In such situations, the contractor may need to obtain information about the ranges of compensation established for comparable institutions in nearby or similar areas. Another method is to use the ranges established for another class of institution and adjust the ranges accordingly. For example, the contractor may, on the basis of its analysis and judgment, establish as reasonable compensation in a given skilled nursing facility (SNF) an appropriate proportion of the compensation paid to administrators of comparably sized hospitals in the same area. However, *when* this approach is taken, the fact that hospitals are generally more complex institutions than SNFs is reflected in the *contractor's* determination *of the reasonableness of owner compensation.*

905.6 Inflation Factor.

Contractors apply an inflation factor to update ranges of reasonable compensation determined for previous years. The CMS furnishes an annual calendar year (CY) inflation factor for this purpose. Following are the CY factors for recent years:

2006 - 3.4%; 2007 - 3.7%; 2008 - 3.0%; 2009 - 1.7%; 2010 - 1.5%; 2011 - 2.0%; 2012 - 2.0%; 2013 - 1.9%; 2014 - 1.9%; *2015 - 1.8%; 2016 - 1.6%*

905.7 Guidelines for Physician Owner Compensation for Rural Health Clinics.

Contractors are responsible for evaluating the reasonableness of physician owner compensation for rural health clinics (RHC) by establishing ranges of compensation for comparable institutions as provided in §905.1. Alternately, contractors may use ranges developed by CMS and presented in the following table, Physician Owner Compensation Reasonable Cost Guidelines for Rural Health Clinics. Note that the ranges set forth in the following table are only for determining the reasonableness of physician owner compensation for the purposes of cost reimbursement of RHCs and are not for the purposes of complying with the physician self-referral law (42 USC 1395nn) and regulations (42 CFR Part 411, Subpart J).

CMS developed ranges of reasonable cost for physician owner compensation from comparable RHCs using RHC Medicare cost reports beginning in Fiscal Year (FY) 2012. CMS analyzed physician compensation, for both hospital-based and freestanding RHCs, that included net expenses for physicians and FTE data, to develop ranges of reasonable cost for physician owner compensation for RHCs. In establishing the ranges, abnormally low and high amounts (less than $90,000 and in excess of $600,000) were trimmed from the data.

CMS aggregated the data by divisions and regions, as defined in the U. S. Census Bureau, to provide ranges of reasonable cost for physician owner compensation for RHCs in the same geographical areas.

CMS trended the data back to 2009 and forward to 2014 using inflation factors from §905.6. The ranges determined as a result of the analysis are presented in the Physician Owner Compensation Reasonable Cost Guidelines for Rural Health Clinics table. The ranges are not intended as limits or caps on physician owner compensation, but may be used as a guide in evaluating the reasonableness of physician owner compensation. On the basis of its judgment and with proper justification, a contractor may allow an amount outside the ranges in the table.

For example, the comparison of physician owner compensation for a cost report beginning in FY 2011 for a provider located in Division 9 might be:

For FY 2011, the provider claimed physician owner compensation for one FTE in the amount of $315,144. Referring to the Physician Owner Compensation Reasonable Cost Guidelines for Rural Health Clinics table, the FY 2011 reasonable physician owner compensation for Division 9 ranges from $285,398 to $312,347. Comparing the $315,144 to the Division 9 range reveals the physician owner compensation claimed exceeds the top of the range. The contractor may hold the provider to the Division 9 range or, on the basis of its judgment and with proper justification may allow the amount claimed as physician owner compensation.

Alternately, reasonable physician owner compensation may be compared on a regional level. Referring to the Physician Owner Compensation Reasonable Cost Guidelines for Rural Health Clinics table, the FY 2011 reasonable physician owner compensation for Region 4 ranges from $279,756 to $310,782. Comparing the $315,144 to the Region 4 range reveals the physician owner compensation claimed exceeds the top of the range. The contractor may hold the provider to the Region 4 range or, on the basis of its judgment and with proper justification may allow the amount claimed as physician owner compensation.

Physician Owner Compensation Reasonable Cost Guidelines for Rural Health Clinics By Census Bureau Regions and Divisions Per FTE

Region	Division		2009		2010		2011		2012		2013		2014	
		Factor*: →	0.017		0.015		0.020		0.020		0.019		0.019	
		* Source: §905.6.	Min	Max	Min	Max	Min	Max	Min	Max	Min	Max	Min	Max
1	1	New England	$275,890	$306,762	$280,029	$311,364	$285,629	$317,591	$291,342	$323,943	$296,877	$330,098	$302,518	$336,370
	2	Middle Atlantic	$213,095	$223,657	$216,292	$227,012	$220,618	$231,552	$225,030	$236,183	$229,306	$240,670	$233,663	$245,243
Subtotal - Region 1: Northeast			$252,636	$264,593	$256,425	$268,562	$261,554	$273,933	$266,785	$279,412	$271,854	$284,721	$277,019	$290,131
2	3	East North Central	$251,684	$276,027	$255,459	$280,167	$260,569	$285,771	$265,780	$291,486	$270,830	$297,024	$275,976	$302,667
	4	West North Central	$266,258	$285,384	$270,252	$289,665	$275,657	$295,458	$281,170	$301,367	$286,512	$307,093	$291,956	$312,928
Subtotal - Region 2: Midwest			$260,249	$281,442	$264,153	$285,663	$269,436	$291,376	$274,825	$297,204	$280,047	$302,851	$285,368	$308,605
3	5	South Atlantic	$218,079	$233,894	$221,350	$237,402	$225,777	$242,150	$230,293	$246,993	$234,669	$251,686	$239,128	$256,468
	6	East South Central	$250,876	$268,628	$254,640	$272,658	$259,732	$278,111	$264,927	$283,673	$269,961	$289,063	$275,090	$294,555
	7	West South Central	$233,620	$244,568	$237,124	$248,236	$241,867	$253,201	$246,704	$258,265	$251,391	$263,172	$256,167	$268,172
Subtotal - Region 3: South			$236,132	$245,690	$239,674	$249,375	$244,468	$254,363	$249,357	$259,450	$254,095	$264,380	$258,923	$269,403
4	8	Mountain	$261,423	$298,011	$265,344	$302,481	$270,651	$308,530	$276,064	$314,701	$281,309	$320,680	$286,654	$326,773
	9	Pacific	$275,667	$301,697	$279,802	$306,223	$285,398	$312,347	$291,106	$318,594	$296,637	$324,647	$302,273	$330,815
Subtotal - Region 4: West			$270,217	$300,186	$274,270	$304,689	$279,756	$310,782	$285,351	$316,998	$290,773	$323,021	$296,298	$329,158

Census Bureau Divisions:

New England Division: Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont
Middle Atlantic Division: New Jersey, New York, Pennsylvania
East North Central Division: Illinois, Indiana, Michigan, Ohio, Wisconsin
West North Central Division: Iowa, Kansas, Minnesota, Missouri, Nebraska, North Dakota, South Dakota
South Atlantic Division: Delaware, District of Columbia, Florida, Georgia, Maryland, North Carolina, South Carolina, Virginia, West Virginia
East South Central Division: Alabama, Kentucky, Mississippi, Tennessee
West South Central Division: Arkansas, Louisiana, Oklahoma, Texas
Mountain Division: Arizona, Colorado, Idaho, Montana, Nevada, New Mexico, Utah, Wyoming
Pacific Division: Alaska, California, Hawaii, Oregon, Washington

906. TYPES OF COMPENSATION - CORPORATIONS

As indicated in §902.2, compensation for the necessary services of a stockholder-employee or an individual described in §901 (other than sole proprietors and partners) includes:

- Salary amounts paid for managerial, administrative, professional, and other services;
- Amounts paid by the institution for the personal benefit of the owner (see §906.1);
- The costs of assets and services which the owner receives from the institution (see §906.1); and
- Deferred compensation. (See §2140.)

Any payments to an owner in excess of a reasonable level do not constitute compensation or any other allowable cost.

906.1 Other Types of Compensation.--There may be instances in which an owner is receiving compensation in a form that, without close scrutiny, might not be recognized as compensation (e.g., fringe benefits). Compensation to an owner may include (1) supplies and services for the personal use of the owner, (2) special merchandise ordered from wholesalers for the owner's personal use, (3) wages of a domestic or other employee who works in the home of the owner, (4) personal use of a car owned by the business, (5) personal insurance premiums paid for the owner, and (6) other fringe benefits as described in §2144.

Any of the above payments must be included in the owner's total compensation to determine its reasonableness when such payments meet the requirements for being categorized as fringe benefits under the definition given in §2144.1. If the requirements of that section are not met, these types of payments cannot be considered compensation.

906.2 Subchapter S Corporation.--Under Federal income tax law, certain corporations can elect to be treated for tax purposes as a partnership. This election, however, has no effect on reimbursement under the Medicare program, and an owner of a Subchapter S corporation is not considered a partner for purposes of this principle.

906.3 Director Fees and Consultant Fees.--All payments by a provider to an owner which are claimed as an allowable cost are included in the owner's total compensation for purposes of determining the reasonableness of the cost claimed. This includes fees received by an owner, regardless of the label placed on them, such as consultant or director fees. The determination as to the reasonableness of such compensation is made by comparing it with amounts paid by comparable institutions for comparable services performed by their employees, rather than by considering the amounts that outside consultants receive.

906.4 Unpaid Compensation.--See §2146.2B.

General.--The compensation of stockholder-employees and individuals described in §901 (other than sole proprietors and partners) is included for a cost reporting period if earned within the period, even if not paid until after the close of the period. However, payment must be made (whether by check or other negotiable instrument, cash or legal transfer of assets such as stocks, bonds, real property, etc.) within 75 days after the close of the period. Where payment is made by check or other negotiable instrument (e.g., a promissory note), these forms of payment must be liquidated through an actual transfer of the provider's assets within 75 days after the close of the period in order to meet the requirements of this section. If payment, including the liquidation of negotiable instruments, is not made within the cost reporting period, or within 75 days thereafter, the unpaid compensation is not includable in allowable costs either in the period when earned or in the period when actually paid.

907. COMPENSATION-SOLE PROPRIETORSHIPS AND PARTNERSHIPS

A. General.--The allowance of compensation for sole proprietors and partners is the value of the services rendered by the owner. Such an amount may or may not be represented as actual payments made to the owner. There is no direct relationship between the compensation allowance of the owner and the amount of operating profit (or loss) of the facility.

In determining the allowance, the contractor is responding to a claim for the value of the services of the owner. That is, the institution will include in its statement of reimbursable cost an allowance for the value of the owner's services and the contractor evaluates the reasonableness of this claim by applying the criteria in this chapter.

B. Actual Payments Made.--Where a provider has claimed as some other cost (for example, see §906.1) an amount paid to a sole proprietor or partner, such amount is combined with the allowance claimed by the provider for the owner's services. This total is then used for determining the reasonableness of the compensation allowance claimed.

C. Other Considerations.--Since the compensation allowance for sole proprietors and partners is dependent upon the value of the necessary services rendered, no allowance is granted where such services are not actually rendered. This is true even if an owner is receiving payments from the provider. Therefore, although a partnership agreement might provide for retired partners to continue to receive a share of the partnership profits even though they are not rendering any services, such payments are not considered allowable costs under the program.

D. Corporation is Partner.--Where a corporation is a partner in a participating provider, the allowance of compensation for the services of stockholder employees of the corporation is limited to the actual remuneration paid. In contrast to sole proprietors and partners, these individuals do receive actual compensation for their services, separate and apart from any distribution of profits made to them by virtue of their ownership interest in the corporation. The compensation paid by the corporation is subject to the test of reasonableness in evaluating the partnership's claimed allowance. Further, since the corporation is considered related to the provider within the meaning of chapter 10, Cost to Related Organizations, the provider also cannot claim amounts for services performed by other employees of the corporation which are in excess of the actual remuneration paid.