an important source of consultative assistance to providers and will be available to deal with questions and problems on a day-to-day basis.

(c) Recordkeeping requirements for new providers. A newly participating provider of services (as defined in §400.202 of this chapter) must make available to its selected intermediary for examination its fiscal and other records for the purpose of determining such provider’s ongoing recordkeeping capability and inform the intermediary of the date its initial Medicare cost reporting period ends. This examination is intended to assure that—

1. The provider has an adequate ongoing system for furnishing the records needed to provide accurate cost data and other information capable of verification by qualified auditors and adequate for cost reporting purposes under section 1815 of the Act; and

2. No financial arrangements exist that will thwart the commitment of the Medicare program to reimburse providers the reasonable cost of services furnished beneficiaries. The data and information to be examined include cost, revenue, statistical, and other information pertinent to reimbursement including, but not limited to, that described in paragraph (d) of this section and in §413.24.

(d) Continuing provider recordkeeping requirements. (1) The provider must furnish such information to the intermediary as may be necessary to—

(i) Assure proper payment by the program, including the extent to which there is any common ownership or control (as described in §413.17(b)(2) and (3)) between providers or other organizations, and as may be necessary to identify the parties responsible for submitting program cost reports;

(ii) Receive program payments; and

(iii) Satisfy program overpayment determinations.

(2) The provider must permit the intermediary to examine such records and documents as are necessary to ascertain information pertinent to the determination of the proper amount of program payments due. These records include, but are not limited to, matters pertaining to—

(i) Provider ownership, organization, and operation;

(ii) Fiscal, medical, and other recordkeeping systems;

(iii) Federal income tax status;

(iv) Asset acquisition, lease, sale, or other action;

(v) Franchise or management arrangements;

(vi) Patient service charge schedules;

(vii) Costs of operation;

(viii) Amounts of income received by source and purpose; and

(ix) Flow of funds and working capital.

(3) The provider, upon request, must furnish the intermediary copies of patient service charge schedules and changes thereto as they are put into effect. The intermediary will evaluate such charge schedules to determine the extent to which they may be used for determining program payment.

(e) Suspension of program payments to a provider. If an intermediary determines that a provider does not maintain or no longer maintains adequate records for the determination of reasonable cost under the Medicare program, payments to such provider will be suspended until the intermediary is assured that adequate records are maintained. Before suspending payments to a provider, the intermediary will, in accordance with the provisions in §405.372(a) of this chapter, send written notice to such provider of its intent to suspend payments. The notice will explain the basis for the intermediary’s determination with respect to the provider’s records and will identify the provider’s recordkeeping deficiencies. The provider must be given the opportunity, in accordance with §405.372(b) of this chapter, to submit a statement (including any pertinent evidence) as to why the suspension must not be put into effect.

the accrual basis of accounting, except for—

(1) Governmental institutions which operate on a cash basis method of accounting. Cost data based on such basis of accounting will be acceptable, subject to appropriate treatment of capital expenditures.

(2) Costs of qualified defined benefit pension plans shall be reported on a cash basis method of accounting, as described at § 413.100(c)(2)(vii)(D) for cost reporting periods beginning on or after October 1, 2011.

(b) Definitions—(1) Cost finding. Cost finding is the process of recasting the data derived from the accounts ordinarily kept by a provider to ascertain costs of the various types of services furnished. It is the determination of these costs by the allocation of direct costs and proration of indirect costs.

(2) Accrual basis of accounting. As used in this part, the term accrual basis of accounting means that revenue is reported in the period in which it is earned, regardless of when it is collected; and an expense is reported in the period in which it is incurred, regardless of when it is paid. (See §413.100 regarding limitations on allowable accrued costs in situations in which the related liabilities are not liquidated timely.)

(c) Adequacy of cost information. Adequate cost information must be obtained from the provider’s records to support payments made for services furnished to beneficiaries. The requirement of adequacy of data implies that the data be accurate and in sufficient detail to accomplish the purposes for which it is intended. Adequate data capable of being audited is consistent with good business concepts and effective and efficient management of any organization, whether it is operated for profit or on a nonprofit basis. It is a reasonable expectation on the part of any agency paying for services on a cost-reimbursement basis. In order to provide the required cost data and not impair comparability, financial and statistical records should be maintained in a manner consistent from one period to another. However, a proper regard for consistency need not preclude a desirable change in accounting procedures if there is reason to effect such change.

(d) Cost finding methods. After the close of the accounting period, providers must use one of the following methods of cost finding to determine the actual costs of services furnished during that period. (These provisions do not apply to SNFs that elect and qualify for prospectively determined payment rates under subpart I of this part for cost reporting periods beginning on or after October 1, 1986. For the special rules that are applicable to those SNFs, see §413.321.) For cost reporting periods beginning after December 31, 1971, providers using the departmental method of cost apportionment must use the step-down method described in paragraph (d)(1) of this section or an “other method” described in paragraph (d)(2) of this section. For cost reporting periods beginning after December 31, 1971, providers using the combination method of cost apportionment must use the modified cost finding method described in paragraph (d)(3) of this section. Effective for cost reporting periods beginning on or after December 31, 1980, HHAs not based in hospitals or SNFs must use the step-down method described in paragraph (d)(1) of this section. (HHAs based in hospitals or SNFs must use the method applicable to the parent institution.) However, an HHA not based in a hospital or SNF that received less than $35,000 in Medicare payment for the immediately preceding cost reporting period, and for whom this payment represented less than 50 percent of the total operating cost of the agency, may use a simplified version of the step-down method, as specified in instructions for the cost report issued by CMS.

(1) Step-down method. This method recognizes that services furnished by certain nonrevenue-producing departments or centers are utilized by certain other nonrevenue-producing centers as well as by the revenue-producing centers. All costs of nonrevenue-producing centers are allocated to all centers that they serve, regardless of whether or not these centers produce revenue. The cost of the nonrevenue-producing center serving the greatest number of other centers, while receiving benefits
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from the least number of centers, is apportioned first. Following the apportionment of the cost of the nonrevenue-producing center, that center will be considered “closed” and no further costs are apportioned to that center. This applies even though it may have received some service from a center whose cost is apportioned later. Generally, if two centers furnish services to an equal number of centers while receiving benefits from an equal number, that center which has the greatest amount of expense should be allocated first.

(2) Other methods—(i) The double-apportionment method. The double-apportionment method may be used by a provider upon approval of the intermediary. This method also recognizes that the nonrevenue-producing departments or centers furnish services to other nonrevenue-producing centers as well as to revenue-producing centers. A preliminary allocation of the costs of non-revenue-producing centers is made. These centers or departments are not “closed” after this preliminary allocation. Instead, they remain “open,” accumulating a portion of the costs of all other centers from which services are received. Thus, after the first or preliminary allocation, some costs will remain in each center representing services received from other centers. The first or preliminary allocation is followed by a second or final apportionment of expenses involving the allocation of all costs remaining in the nonrevenue-producing functions directly to revenue-producing centers.

(ii) More sophisticated methods. A more sophisticated method designed to allocate costs more accurately may be used by the provider upon approval of the intermediary. However, having elected to use the double-apportionment method, the provider may not thereafter use the step-down method without approval of the intermediary. Written request for the approval must be made on a prospective basis and must be submitted before the end of the fourth month of the prospective reporting period. Likewise, once having elected to use a more sophisticated method, the provider may not thereafter use either the double-apportionment or step-down methods without prior approval of the intermediary.

(3) Modified cost finding for providers using the Combination Method for reporting periods beginning after December 31, 1971. This method differs from the step-down method in that services furnished by nonrevenue-producing departments or centers are allocated directly to revenue-producing departments or centers even though these services may be utilized by other nonrevenue-producing departments or centers. In the application of this method the cost of nonrevenue-producing centers having a common basis of allocation are combined and the total distributed to revenue-producing centers. All nonrevenue-producing centers having significant percentages of cost in relation to total costs will be allocated this way. The combined total costs of remaining nonrevenue-producing costs centers will be allocated to revenue-producing cost centers in the proportion that each bears to total costs, direct and indirect, already allocated. The bases which are to be used and the centers which are to be combined for allocation are not optional but are identified and incorporated in the cost report forms developed for this method. Providers using this method must use the program cost report forms devised for it. Alternative forms may not be used without prior approval by CMS based upon a written request by the provider submitted through the intermediary.

(4) Temporary method for initial period. If the provider is unable to use either cost-finding method when it first participates in the program, it may apply to the intermediary for permission to use some other acceptable method that would accurately identify costs by department or center, and appropriately segregate inpatient and outpatient costs. Such other method may be used for cost reports covering periods ending before January 1, 1968.

(5) Simplified optional reimbursement method for small, rural hospitals with distinct parts for cost reporting periods beginning on or after July 20, 1982. (i) A rural hospital with a Medicare-certified distinct part SNF may elect to be reimbursed for services furnished in its hospital general routine service area and distinct part SNF using the
reimbursement method specified in §413.53 for swing-bed hospitals, if it meets the following conditions:

(A) The institution is located in a rural area as defined in §482.66 of this chapter.

(B) On the first day of the cost reporting period, the hospital and distinct part SNF have fewer than 50 beds in total (with the exception of beds for newborns and beds in intensive care type inpatient units).

(ii) In applying the optional reimbursement method, only those beds located in the hospital general routine service area and in the distinct part SNF certified by Medicare are combined into a single cost center for purposes of cost finding.

(iii) The reasonable cost of the routine extended care services is determined in accordance with §413.114(c). The reasonable cost of the hospital general routine services is determined in accordance with §413.53(a)(2). The hospital must make its election to use the optional swing-bed reimbursement method in writing to the intermediary before the beginning of the hospital’s cost reporting year. The hospital must make any request to revoke the election in writing before the beginning of the affected cost reporting period.

(iv) The hospital must make its election to use the optional swing-bed reimbursement method in writing to the intermediary before the beginning of the hospital’s cost reporting year. The hospital must make any request to revoke the election in writing before the beginning of the affected cost reporting period.

(v) The intermediary must approve requests to terminate use of the optional swing-bed reimbursement method, only those beds located in the hospital general routine service area and in the distinct part SNF certified by Medicare are combined into a single cost center for purposes of cost finding.

(6) Provider-based entities and departments: Preventing duplication of cost. In some situations, the main provider in a provider-based complex may purchase services for a provider-based entity or for a department of the provider through a contract for services (for example, a management contract), directly assigning the costs to the provider-based entity or department and reporting the costs directly in the cost center for that entity or department. In any situation in which costs are directly assigned to a cost center, there is a risk of excess cost in that cost center resulting from the directly assigned costs plus a share of overhead improperly allocated to the cost center which duplicates the directly assigned costs. This duplication could result in improper Medicare payment to the provider. Where a provider has purchased services for a provider-based entity or for a provider department, like general service costs of the provider (for example, like costs in the administrative and general cost center) must be separately identified to ensure that they are not improperly allocated to the entity or the department. If the like costs of the main provider cannot be separately identified, the costs of the services purchased through a contract must be reclassified to the main provider and allocated among the main provider’s benefiting cost centers.

Example: A provider-based complex is composed of a hospital and a hospital-based rural health clinic (RHC). The hospital furnishes the entirety of its own administrative and general costs internally. The RHC, however, is managed by an independent contractor through a management contract. The management contract provides a full array of administrative and general services, with the exception of patient billing. The hospital directly assigns the costs of the RHC’s management contract to the RHC cost center (for example, Form CMS 2552–96, Worksheet A, Line 71). A full allocation of the hospital’s administrative and general costs to the RHC cost center would duplicate most of the RHC’s administrative and general costs. However, an allocation of the hospital’s cost (included in hospital administrative and general costs) of its patient billing function to the RHC would be appropriate. Therefore, the hospital must include the costs of the patient billing function in a separate cost center to be allocated to the benefiting cost centers, including the RHC cost center. The remaining hospital administrative and general costs would be allocated to all cost centers, excluding the RHC cost center. If the hospital is unable to isolate the costs of the patient billing function, the costs of the RHC’s management contract must be reclassified to the hospital administrative and general cost center to be allocated among all cost centers, as appropriate.

(7) Costs of services furnished to free-standing entities. The costs that a provider incurs to furnish services to free-standing entities with which it is associated are not allowable costs of that provider. Any costs of services furnished to a free-standing entity must be identified and eliminated from the allowable costs of the servicing provider, to prevent Medicare payment to
that provider for those costs. This may be done by including the free-standing entity on the cost report as a nonreim-
bursable cost center for the purpose of allocating overhead costs to that entity. If this method would not result in 
an accurate allocation of costs to the entity, the provider must develop de-
tailed work papers showing how the cost of services furnished by the pro-
vider to the entity were determined. These costs are removed from the 
applicable cost centers of the servicing provider.

(e) Accounting basis. The cost data submitted must be based on the ac-
crual basis of accounting which is rec-
ognized as the most accurate basis for 
determining costs. However, govern-
mental institutions that operate on a 
cash basis of accounting may submit 
their cost data on the cash basis subject to 
appropriate treatment of capital ex-
penditures.

(f) Cost reports. For cost reporting 
purposes, the Medicare program re-
quires each provider of services to sub-
mit periodic reports of its operations 
that generally cover a consecutive 12-
month period of the provider’s oper-
ations. Amended cost reports to revise 
cost report information that has been 
previously submitted by a provider 
may be permitted or required as deter-
mined by CMS.

(1) Cost reports—Terminated providers 
and changes of ownership. A provider 
that voluntarily or involuntarily 
ceases to participate in the Medicare 
program or experiences a change of 
ownership must file a cost report for 
that period under the program begin-
ning with the first day not included in 
a previous cost reporting period and 
ending with the effective date of termi-
nation of its provider agreement or 
change of ownership.

(2) Due dates for cost reports. (i) Cost 
reports are due on or before the last 
day of the fifth month following the 
close of the period covered by the re-
port. For cost reports ending on a day 
other than the last day of the month, 
cost reports are due 150 days after the 
last day of the cost reporting period.

(ii) Extensions of the due date for fil-
ing a cost report may be granted by the 
intermediary only when a provider's 
operations are significantly adversely 
affected due to extraordinary cir-
cumstances over which the provider 
has no control, such as flood or fire.

(3) Changes in cost reporting periods. A 
provider may change its cost reporting 
period if a change in ownership is ex-
perienced or if the—

(i) Provider requests the change in 
writing from its intermediary;

(ii) Intermediary receives the request 
at least 120 days before the close of the 
next reporting period requested by the 
provider; and

(iii) Intermediary determines that 
good cause for the change exists. Good 
cause would not be found to exist if the 
effect is to change the initial date that 
a hospital would be affected by the rate 
of increase ceiling (see §413.40), or be 
paid under the prospective payment 
systems (see part 412 of this chapter).

(4) Electronic submission of cost reports. 
(i) As used in this paragraph, “pro-
vider” means a hospital, skilled nurs-
ing facility, home health agency, hos-
pice, organ procurement organization, 
rural health clinic, Federally qualified 
health clinic, community mental 
health center, or end-stage renal dis-
fase facility.

(ii) Effective for cost reporting peri-
ods beginning on or after October 1, 
1989 for hospitals, cost reporting peri-
ods ending on or after December 31, 
1996 for skilled nursing facilities and 
home health agencies, cost reporting 
periods ending on or after December 31, 
2004 for hospices, and end-stage renal 
disease facilities, and cost reporting 
periods ending on or after March 31, 
2005 for organ procurement organiza-
tions, rural health clinics, Federally 
qualified health centers, and commu-
nity mental health centers, a provider 
is required to submit cost reports in a 
standardized electronic format. The 
provider’s electronic program must be 
capable of producing the CMS stand-
ardized output file in a form that can 
be read by the fiscal intermediary’s 
automated system. This electronic file, 
which must contain the input data re-
quired to complete the cost report and 
to pass specified edits, must be for-
warded to the fiscal intermediary for 
processing through its system.

(iii) The fiscal intermediary stores 
the provider’s as-filed electronic cost 
report and may not alter that file for
any reason. The fiscal intermediary makes a “working copy” of the as-filed electronic cost report to be used, as necessary, throughout the settlement process (that is, desk review, processing audit adjustments, and final settlement). The provider’s electronic program must be able to disclose if any changes have been made to the as-filed electronic cost report after acceptance by the intermediary. If the as-filed electronic cost report does not pass all specified edits, the fiscal intermediary must return it to the provider for correction. For purposes of the requirements in paragraph (f)(2) of this section concerning due dates, an electronic cost report is not considered to be filed until it is accepted by the intermediary.

(iv) Effective for cost reporting periods ending on or after September 30, 1994 for hospitals, cost reporting periods ending on or after December 31, 1996 for skilled nursing facilities and home health agencies, cost reporting periods ending on or after December 31, 2004 for hospices and end-stage renal disease facilities, and cost reporting periods ending on or after March 31, 2005 for organ procurement organizations, rural health clinics, Federally qualified health centers, and community mental health centers, a provider must submit a hard copy of a settlement summary, a statement of certain worksheet totals found within the electronic file, and a statement signed by its administrator or chief financial officer certifying the accuracy of the electronic file or the manually prepared cost report. During a transition period (first two cost-reporting periods on or after December 31, 2004 for hospices and end-stage renal disease facilities, and the first two cost-reporting periods on or after March 31, 2005 for organ procurement organizations, rural health clinics, Federally qualified health centers, community mental health centers) providers must submit a hard copy of the completed cost report forms in addition to the electronic file. The following statement must immediately precede the dated signature of the provider’s administrator or chief financial officer:

I hereby certify that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet Statement of Revenue and Expenses prepared by [Provider Name(s) and Number(s)] for the cost reporting period beginning [ ] and ending [ ] and that to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

(v) A provider may request a delay or waiver of the electronic submission requirement in paragraph (f)(4)(ii) of this section if this requirement would cause a financial hardship or if the provider qualifies as a low or no Medicare utilization provider. The provider must submit a written request for delay or waiver with necessary supporting documentation to its intermediary no later than 30 days after the end of its cost reporting period. The intermediary reviews the request and forwards it, with a recommendation for approval or denial, to CMS central office within 30 days of receipt of the request. CMS central office either approves or denies the request and notifies the intermediary within 60 days of receipt of the request.

(5) An acceptable cost report submission is defined as follows:

(i) All providers—The provider, must complete and submit the required cost reporting forms, including all necessary signatures. A cost report is rejected for lack of supporting documentation only if it does not include the Provider Cost Reimbursement Questionnaire. Additionally, a cost report for a teaching hospital is rejected for lack of supporting documentation if the cost report does not include a copy of the Intern and Resident Information System diskette.

(ii) For providers that are required to file electronic cost reports—In addition to the requirements of paragraphs (f)(4) and (f)(5)(i) of this section, the provider must submit its cost reports in an electronic cost report format in conformance with the requirements contained in the Electronic Cost Report (ECR)
Specifications Manual (unless the provider has received an exemption from CMS).

(iii) The intermediary makes a determination of acceptability within 30 days of receipt of the provider’s cost report. If the cost report is considered unacceptable, the intermediary returns the cost report with a letter explaining the reasons for the rejection. When the cost report is rejected, it is deemed an unacceptable submission and treated as if a report had never been filed.

(g) Exception from full cost reporting for lack of program utilization. If a provider does not furnish any covered services to Medicare beneficiaries during a cost reporting period, it is not required to submit a full cost report. It must, however, submit an abbreviated cost report, as prescribed by CMS.

(h) Waiver of full or simplified cost reporting for low program utilization. (1) If the provider has had low utilization of covered services by Medicare beneficiaries (as determined by the intermediary) and has received correspondingly low interim payments for the cost reporting period, the intermediary may waive a full cost report or the simplified cost report described in §413.321 if it decides that it can determine, without a full or simplified report, the reasonable cost of covered services provided during that period.

(2) If a full or simplified cost report is waived, the provider must submit within the same time period required for full or simplified cost reports:

(i) The cost reporting forms prescribed by CMS for this situation; and

(ii) Any other financial and statistical data the intermediary requires.

Subpart C—Limits on Cost Reimbursement

§ 413.30 Limitations on payable costs.

(a) Introduction—(1) Scope. This section implements section 1861(v)(1)(A) of the Act by setting forth the general rules under which CMS may establish limits on SNF and HHA costs recognized as reasonable in determining Medicare program payments. It also sets forth rules governing exemptions and exceptions to limits established under this section that CMS may make as appropriate in considering special needs or situations of particular providers.

(2) General principle. Reimbursable provider costs may not exceed the costs CMS estimates to be necessary for the efficient delivery of needed health care services. CMS may establish estimated cost limits for direct or indirect overall costs or for costs of specific services or groups of services. CMS imposes these limits prospectively and may calculate them on a per admission, per discharge, per diem, per visit, or other basis.

(b) Procedure for establishing limits. (1) In establishing limits under this section, CMS may classify SNFs and HHAs by factors that CMS finds appropriate and practical, including the following:

(i) Type of services furnished.

(ii) Geographical area where services are furnished, allowing for grouping of noncontiguous areas having similar demographic and economic characteristics.

(iii) Size of institution.

(iv) Nature and mix of services furnished.

(v) Type and mix of patients treated.

(2) CMS bases its estimates of the costs necessary for efficient delivery of health services on cost reports or other data providing indicators of current costs. CMS adjusts current and past period data to arrive at estimated costs for the prospective periods to which limits are applied.

(3) Before the beginning of a cost period to which revised limits will be applied, CMS publishes a notice in the FEDERAL REGISTER, establishing cost limits and explaining the basis on which they are calculated.

(4) In establishing limits under paragraph (b)(1) of this section, CMS may find it inappropriate to apply particular limits to a class of SNFs or HHAs due to the characteristics of the SNF or HHA class, the data on which CMS bases those limits, or the method by which CMS determines the limits.