

section, and are not allowable as separate costs.

(2) *Premium payments for single- and multi-employer plans.* The amount of PBGC premiums paid for basic benefits (flat rate or variable, excluding amounts paid out of the corpus or earnings of the trust) by a provider of services who sponsors a QDBP are allowable under the program.

(3) *Liability for missing participants or beneficiaries.* The total amount paid to the PBGC by a provider of services who sponsors a QDBP (excluding amounts paid out of the corpus or earnings of the trust) of the benefit transfer amount (as described in 29 CFR 4050.103(d)) for all missing participants or beneficiaries of the QDBP, is allowable under the program.

(4) *Plan termination due to distress.* For a defined benefit plan that terminated with insufficient assets to pay all of the plan benefits, which resulted in the PBGC making payment of vested benefits up to limits defined by law in accordance with 29 CFR part 4022, such amounts contributed to the QDBP by the provider of services who sponsors the QDBP are allowable. Benefits paid to the participants and beneficiaries of the QDBP by the PBGC are unallowable.

(5) *Restored plan payments.* If the PBGC issues or has issued a plan restoration order as described in 29 CFR part 4047, the amounts that the provider of services repays to the PBGC for guaranteed benefits and related expenses under the plan while the plan was in terminated status, and any administrative costs assessed by the PBGC, excluding penalties, are allowable.

[87 FR 49406, Aug. 10, 2022]

§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 Medicare payment purposes the costs are allowable in the year in which the costs are accrued and claimed for Medicare payment 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 payment Medicare 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 Medicare payment in the year of the accrual, the requirements set forth below must be met with respect to the 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 Medicare payment 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 de-

mand 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 Medicare payment 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 Medicare payment 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]

§413.102 Compensation of owners.

(a) *Principle.* A reasonable allowance of compensation for services of owners is an allowable cost provided that the services are actually performed in a necessary function.

(b) *Definitions*—(1) *Compensation.* Compensation means the total benefit received by the owner for the services he furnishes to the institution. It includes the following items:

(i) Salary amounts paid for managerial, administrative, professional, and other services.

(ii) Amounts paid by the institution for the personal benefit of the proprietor.

(iii) The cost of assets and services that the proprietor receives from the institution.

(iv) Deferred compensation.

(2) *Reasonableness.* Reasonableness requires that the compensation allowance—

(i) Be such an amount as would ordinarily be paid for comparable services by comparable institutions; and

(ii) Depend upon the facts and circumstances of each case.

(3) *Necessary.* Necessary requires that the function be—

(i) Such that had the owner not furnished the services, the institution