



DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

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

July 9, 2010

Report Number: A-05-09-00062

Mr. Daniel Houston  
President  
Houston Companies, Inc  
1481 South Grant Avenue  
Crawfordsville, IN 47933

Dear Mr. Houston:

Enclosed is the U.S. Department of Health & Human Services (HHS), Office of Inspector General (OIG), final report entitled *Review of Houston Companies Medicare Cost Reports for Calendar Year 2005*. We will forward a copy of this report to the HHS action official noted on the following page for review and any action deemed necessary.

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

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

If you have any questions or comments about this report, please do not hesitate to call me, or contact Lynn Barker, Audit Manager, at (317) 226-7833 ext 21 or through email at [Lynn.Barker@oig.hhs.gov](mailto:Lynn.Barker@oig.hhs.gov). Please refer to report number A-05-09-00062 in all correspondence.

Sincerely,

/James C. Cox/  
Regional Inspector General  
for Audit Services

Enclosure

**Direct Reply to HHS Action Official:**

Nanette Foster Reilly  
Consortium Administrator  
Consortium for Financial Management & Fee for Service Operations (CFMFFSO)  
Centers for Medicare & Medicaid Services  
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Department of Health & Human Services

**OFFICE OF  
INSPECTOR GENERAL**

**REVIEW OF HOUSTON COMPANIES  
MEDICARE COST REPORTS FOR  
CALENDAR YEAR 2005**



Daniel R. Levinson  
Inspector General

July 2010  
A-05-09-00062

# *Office of Inspector General*

<http://oig.hhs.gov>

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## **OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS**

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

## **EXECUTIVE SUMMARY**

### **BACKGROUND**

Prior to 1998, Medicare paid the cost of individual services provided to Skilled Nursing Facility (SNF) patients using a retrospective reimbursement system. Currently, Medicare pays SNFs a daily rate to cover skilled services provided to Medicare patients during each day of a covered SNF stay; however, it does not base payments on the cost of individual services. Instead, SNFs complete an assessment form called a Minimum Data Set that places a patient in a specific payment group, known as a Resource Utilization Group, based on the patient's care and resource needs.

Providers are required to fill out and submit cost reports on an annual basis. The accuracy of the cost reports is critical. The Centers for Medicare & Medicaid Services (CMS) uses this information for various rate-setting and payment-refinement activities.

Houston Companies, Inc. (Houston), a private for-profit organization, owned and operated two SNFs and a home office, as well as private assisted-living apartments and a pharmacy located in Crawfordsville, Indiana during calendar year (CY) 2005. Houston reported costs totaling \$12.2 million on Medicare cost reports for its two SNFs and its home office during CY 2005.

### **OBJECTIVE**

Our objective was to determine whether Houston reported costs on its CY 2005 Medicare cost reports that complied with Federal requirements.

### **SUMMARY OF FINDINGS**

Houston did not always report costs on its CY 2005 Medicare cost reports that complied with Federal requirements. Of the \$12,187,097 Houston reported on its CY 2005 Medicare cost reports, \$156,733 did not comply and was therefore, unallowable.

The cost reports were inaccurate because Houston did not implement sufficient internal controls and procedures to ensure that it reported Medicare costs in compliance with Federal requirements.

### **RECOMMENDATIONS**

We recommend that Houston:

- submit revised CY 2005 Medicare cost reports to CMS and reduce costs by \$156,733 that were unallowable, and
- implement internal controls and procedures to ensure that Medicare cost reports include costs that comply with Federal requirements.

## **AUDITEE COMMENTS**

In its comments on our draft report, Houston disagrees that bad debts totaling \$126,746 did not comply with Federal requirements and are therefore, unallowable. Houston stated that all of the bad debts related to covered services as they were Medicare coinsurance payments due from Medicare Part A residents. Houston agreed that the remaining \$29,987 in expenses did not comply and agreed with our second recommendation.

Houston's comments are included in their entirety as the Appendix.

## **OFFICE OF INSPECTOR GENERAL RESPONSE**

After reviewing Houston's comments, we maintain our findings and recommendations are valid. The bad debts were classified as non-Medicare services on Houston's Medicaid cost reports. Furthermore, Houston Companies did not make adjustments to remove the bad debts from its 2005 Medicare cost reports as it did in prior years.

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## INTRODUCTION

### BACKGROUND

Prior to 1998, Medicare paid the cost of individual services provided to Skilled Nursing Facility (SNF) patients using a retrospective reimbursement system. Currently, Medicare pays SNFs a daily rate to cover skilled services provided to Medicare patients during each day of a covered SNF stay; however, it does not base payments on the cost of individual services. Instead, SNFs complete an assessment form called a Minimum Data Set that places a patient in a specific payment group, known as a Resource Utilization Group, based on the patient's care and resource needs.

Skilled nursing facilities provide daily services that include skilled nursing care; speech, occupational, and physical therapies; and other services. Services must be provided by, or under the direct supervision of, skilled nursing or rehabilitation professionals and be for a condition previously treated at a hospital.

### Reporting of Costs on the Medicare Cost Report

Although Medicare pays SNFs in accordance with the prospective payment system, providers are required to fill out and submit cost reports in compliance with Federal cost reporting requirements regulations (42 CFR §§ 413.20 and 413.24) on an annual basis. The *Provider Reimbursement Manual* (part 2, chapter 35) provides detailed instructions to SNFs to complete the Medicare cost reports. The instructions require providers to make adjustments and remove all costs not related to patient care, as well as all costs related to luxury items or services because these costs are not allowable for Medicare purposes.

The accuracy of the cost reports is critical. The Centers for Medicare & Medicaid Services (CMS) uses the cost report information for various rate-setting and payment-refinement activities that include updating price indexes for revising Medicare payment rates, projecting future Medicare expenditures, and determining adequate deductibles and premiums. In addition, the Government Accountability Office, the Office of Management and Budget, and other Federal agencies depend on accurate cost report information when conducting audits and evaluating SNFs.

### Federal Requirements

Federal regulations (42 CFR § 413.24(a)) state providers must submit adequate cost data. This cost data must be based on a provider's financial and statistical records, which must be capable of verification by qualified auditors. The cost data must be based on an approved method of cost finding and on the accrual basis of accounting. Pursuant to 1861(v)(1)(A) of the Social Security Act (the Act), the reasonable cost of any services shall be the cost actually incurred, excluding there from any part of incurred cost found to be unnecessary in the efficient delivery of needed health services. Also pursuant to 1888(e)(2)(A)(i) of the Act, covered skilled nursing facility services are post-hospital extended care services including supervised nursing care, bed and board, therapy services, medical social services, supplies and other services necessary to the health of the patients.

## **Houston Companies Organizational and Corporate Structure**

Houston Companies, Inc. (Houston), a private for-profit company, owned and operated two SNFs and a home office during calendar year 2005. Houston is comprised of the following five corporations:

- Houston Companies, Inc. (Home Office) is the home office located in Crawfordsville, Indiana.
- DHE, Inc., doing business as Ben Hur nursing home (Ben Hur), is a SNF located in Crawfordsville, Indiana.
- Houston Development, Inc., doing business as Williamsburg nursing home (Williamsburg), is a SNF located in Crawfordsville, Indiana.
- Houston Group Homes, Inc. consists of five group homes including Cedar Pointe, located in Lebanon, Indiana; Market Hall, located in Crawfordsville, Indiana; Penn Hall, located in Crawfordsville, Indiana; Pine Ridge, located in Lebanon, Indiana; and White Hall, located in Crawfordsville, Indiana.
- Village Drug Store, Inc. (Village Drug Store) located in Crawfordsville, Indiana, supplies prescription drugs and other medical supplies primarily to Houston's nursing homes and group homes and their patients.

Houston submitted Medicare cost reports for its home office and its two SNFs for CY 2005 totaling \$12,187,097.

## **OBJECTIVE, SCOPE, AND METHODOLOGY**

### **Objective**

Our objective was to determine whether Houston reported costs on its CY 2005 Medicare cost reports that complied with Federal requirements.

### **Scope**

We reviewed Houston's two SNFs (Ben Hur and Williamsburg) and home office Medicare cost reports which identified costs totaling \$12,187,097 for CY 2005. We did not review any costs associated with Houston Group Homes, Inc. or the Village Drug Store, Inc.

We limited our internal control review to Houston's policies, procedures, and controls over reporting costs reported on the Medicare cost reports for CY 2005.

We performed fieldwork at Houston's home office in Crawfordsville, Indiana.

### **Methodology**

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidelines;
- reviewed Houston's policies and procedures related to reporting Medicare expenses on its cost reports;
- reconciled the cost reports to supporting documentation and accounting records for CY 2005;
- interviewed Houston officials to identify and understand policies and procedures for completing Medicare cost reports;
- traced judgmentally selected transactions totaling \$2,012,216 to payroll reports, canceled checks, timesheets, pay notices, vouchers, invoices, and other supporting documentation;
- reviewed bonuses and hours worked summaries to determine if bonuses and hours paid were reasonable in accordance with Houston's policy; and
- computed cost adjustments for nursing homes and the home office and coordinated the results of our audit with the auditee.

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

## **FINDINGS AND RECOMMENDATIONS**

Houston did not always report costs on its CY 2005 Medicare cost reports that complied with Federal requirements. Of the \$12,187,097 Houston reported on its CY 2005 Medicare cost reports, \$156,733 did not comply and was therefore, unallowable.

The cost reports were inaccurate because Houston did not implement sufficient internal controls and procedures to ensure that it reported Medicare costs in compliance with Federal requirements.

### **UNALLOWABLE COSTS**

#### **Federal Requirements**

Federal regulations (42 CFR § 413.89) state that bad debts, charity, and courtesy allowances are deductions from revenue and are not to be included in allowable costs. However, bad debts attributable to the deductibles and coinsurance amounts are reimbursable under the program if related to covered services.

Federal regulations (42 CFR § 413.24(c)) state that adequate cost information must be obtained from the provider's records to support payments made for services furnished to beneficiaries.

Federal regulations (42 CFR § 413.9) state that all payments to providers of services must be based on the reasonable cost of services covered under Medicare and related to the care of beneficiaries. Reasonable cost included all necessary and proper costs incurred in furnishing the services, subject to principles relating to specific items of revenue and cost.

Pursuant to section 2105.10 of part 1 of the *Provider Reimbursement Manual*, costs incurred by providers for fines or monetary penalties imposed for violations of Federal, State, or local laws are not allowable.

### **Unallowable Costs Reported**

Houston reported \$156,733 for unallowable costs on its Medicare cost reports for CY 2005.

**Table 1: Summary of Unallowable Costs Reported**

<b>Unallowable Costs</b>	<b>CY 2005</b>
Bad Debts	\$126,746
Real Estate and Property Taxes	11,760
Mortgage Interest and Insurance For Rental Properties	7,384
Non-Operational Facility	3,513
Village Drug Store Utilities	3,136
Vehicles Not Used For Patient Care	2,836
Overtime Paid Not Associated With Patient Care	641
Traffic Ticket	467
Non-Medicare Facilities	250
<b>Total</b>	<b>\$156,733</b>

#### *Bad Debts*

Houston reported unallowable costs totaling \$126,746 on the Ben Hur (\$72,150) and Williamsburg (\$54,596) SNF cost reports for bad debts related to Medicaid. These costs were unallowable because the costs represented services not covered under Medicare.

#### *Unsupported Real Estate and Property Taxes*

Houston overstated real estate and property taxes by \$11,760 on the Ben Hur SNF cost report (\$8,731) and on the Williamsburg SNF cost report (\$3,029). These costs were unallowable because the reported taxes were not supported by the tax statements.

*Insurance for Rental Properties and Mortgage Interest*

Houston reported \$7,384 on the home office and Ben Hur cost reports for insurance policies (\$5,642) for rental properties and mortgage interest (\$1,742). These costs were unallowable because they were unrelated to Medicare patient care.

*Non-Operational Facility*

Houston reported \$3,513 on the Ben Hur SNF cost report for 2005 for utility expenses related to a non-operational facility, which Houston had closed in 2002. These costs were unallowable because they were unrelated to Medicare patient care,

*Village Drug Store*

Houston reported \$3,136 on the Ben Hur SNF cost report for CY 2005 for the Village Drug Store's utility expenses, which were not directly associated with Medicare patient care activities. These costs were unallowable because they were unrelated to Medicare patient care,

*Vehicles Not Used for Patient Care*

Houston reported \$2,836 related to vehicles costs on the home office cost report and the Ben Hur and Williamsburg SNFs cost reports for CY 2005. The costs included license plates (\$1,151) and interest from financing (\$1,685) for vehicles that were not used for patient care.

**Table 2: Costs Reported for Vehicles Unrelated to Medicare Patient Care**

<b>Cost Report and Associated Expenses</b>	<b>CY 2005</b>
Home Office -License Plates	\$679
Williamsburg -License Plates	472
Ben Hur – Interest from Financing	1,685
<b>Total</b>	<b>\$2,836</b>

These costs were unallowable because they were unrelated to Medicare patient care,

*Employee Overtime Not Related to Patient Care*

Houston reported \$641 for employees' paid overtime for hours not associated with patient care. These costs were unallowable because they were unrelated to Medicare patient care,

**Table 3: Overtime Unrelated to Medicare Patient Care**

<b>Cost Report</b>	<b>CY 2005</b>
Williamsburg	\$521
Ben Hur	88
Home Office	32
<b>Total</b>	<b>\$641</b>

### *Traffic Ticket*

Houston reported \$467 on the Williamsburg 2005 cost report for a traffic ticket on its laundry truck. Pursuant to section 2105.10 of part 1 of the Provider Reimbursement Manual, this cost is unallowable because it is a fine imposed for violating local laws.

### *Non-Medicare-Related Facilities*

Houston reported \$250 on the home office cost report for bonuses related to Houston's private, non-Medicare-related facilities for CY 2005. These costs were unallowable because they were unrelated to Medicare patient care,

## **HOUSTON INTERNAL CONTROLS**

The cost reports were inaccurate because Houston did not implement sufficient internal controls and procedures to ensure that it reported Medicare costs in compliance with Federal requirements.

## **RECOMMENDATIONS**

We recommend that Houston:

- submit revised CY 2005 Medicare cost reports to CMS and reduce costs by \$156,733 that were not allowable, and
- implement internal controls and procedures to ensure that Medicare cost reports include costs that comply with Federal requirements.

## **AUDITEE COMMENTS**

In its comments on our draft report, Houston disagrees that bad debts totaling \$126,746 did not comply with Federal requirements and are therefore, unallowable. Houston stated that all of the bad debts related to covered services as they were Medicare coinsurance payments due from Medicare Part A residents. Houston agreed that the remaining \$29,987 in expenses did not comply and agreed with our second recommendation.

Houston's comments are included in their entirety as the Appendix.

## **OFFICE OF INSPECTOR GENERAL RESPONSE**

After reviewing Houston's comments, we maintain our findings and recommendations are valid. The bad debts were classified as non-Medicare services on Houston's Medicaid cost reports. Furthermore, Houston Companies did not make adjustments to remove the bad debts from its 2005 Medicare cost reports as it did in prior years.

# **APPENDIX**

**APPENDIX: AUDITEE COMMENTS**

**HOUSTON COMPANIES, INC.**

HEALTH CARE PROVIDERS SINCE 1956

1481 SOUTH GRANT AVENUE

P. O. BOX 661

CRAWFORDSVILLE, INDIANA 47933

PHONE: (765) 362-0905 – FAX: (765) 362-1268

June 25, 2010

James C. Cox, Regional Inspector General for Audit Services  
Department of Health and Human Services  
Office of Audit Services, Region V  
233 North Michigan Avenue  
Suite 1360  
Chicago, IL 60601

Re: Written comments regarding Report Number: A-05-09-00062

Mr. Cox,

Enclosed please find Houston Companies' written comments regarding the OIG draft report entitled "Review of Houston Companies Medicare Cost Reports for Calendar Year 2005." The electronic copy requested in your letter will be emailed to Lynn Barker, Audit Manager.

**FINDINGS AND RECOMMENDATIONS**

- Nonconcurrency: Houston disagrees that \$156,733 did not comply and was therefore, unallowable. Houston disagrees the bad debts totaling \$126,746 did not comply and are therefore, unallowable.
- Concurrence: Houston agrees \$29,987 did not comply.

**UNALLOWABLE COSTS REPORTED**

*Bad Debts*

As stated on the bottom of page 3 of the draft audit, "bad debts attributable to the deductibles and coinsurance amounts are reimbursable under the program if related to covered services." All the costs totaling \$126,746 on the Ben Hur (\$72,150) and Williamsburg (\$54,596) SNF cost reports for bad debts related to covered services as they were Medicare coinsurance due from Medicare Part A residents. Consequently,

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Houston does not concur with the bad debt adjustment as these costs are allowable per page 3 of the audit as well as the regulations attached (Attachment 1).

*Unsupported Real Estate and Property Taxes*

Houston will not dispute the Real Estate and Property taxes adjustment. This error occurred due to delays in receiving our Real and Property tax statements. We based our Real Estate and Property tax expense on prior year statements and received the current year's statements after the companies' year ends. We did adjust Real Estate and Property tax expense in subsequent years to correct the over reporting in 2005.

*Insurance for Rental Properties and Mortgage Interest*

The rental properties are residential houses that border Ben Hur and are owned by Ben Hur and are rented to employees and non-employees as single family residences.

*Non-Operational Facility*

Houston will not dispute the Non-Operational Facility adjustments. The expenses for this closed facility are coded to non-patient related accounts to be removed from the Medicare Cost reports. These bills were miscoded and consequently were not removed.

*Village Drug Store*

Two related party businesses rent an office building owned by Ben Hur. Per the lease, Ben Hur paid for the utilities. Houston failed to remove the utility cost in its preparation of the cost reports. The lease has been amended so that the related businesses pay their utilities directly.

*Vehicles Not Used for Patient Care*

Houston will not dispute the vehicle costs adjustments.

*Employee Overtime Not Related to Patient Care*

Houston will not dispute the overtime adjustments.

*Traffic Ticket*

Houston will not dispute the traffic ticket.

*Non-Medicare-Related Facilities*

Houston will not dispute the Non-Medicare-Related Facilities.

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As stated on page *i* of the draft audit, the reporting of \$29,987 of unallowable costs had no affect on Houston's 2005 Medicare income. Medicare no longer pays the cost of individual services provided to SNF patients using a retrospective reimbursement system.

Houston contends the errors totaling \$29,987 had little to no affect on CMS in their data collection used for various rate-setting and payment-refinement activities. To require Houston to submit revised CY 2005 Medicare cost reports in 2010 for the sole purpose of rate-setting and payment-refinement activities that were done four years ago seems like a waste of resources.

Upon the receipt of the final audit from the OIG, Houston:

- will contact the HHS action official to determine if it will be required to submit revised CY 2005 Medicare cost reports to CMS. If the action official determines they are required, Houston will submit revised reports and reduce costs by \$29,987 that were not allowable utilizing its current Medicare Cost Report software,
- will implement internal controls and procedures to ensure that Medicare cost reports include costs that comply with Federal requirements.

Sincerely,



Daniel Houston, President  
Houston Companies, Inc.

Enclosure

# Attachment 1

## Centers for Medicare & Medicaid Services, HHS

§ 413.89

(i) *Applicable hold-harmless percentage.* The applicable hold-harmless percentages for each year in which the residency reduction plan is in effect are as follows:

- (1) 100 percent for the first and second residency training years;
- (2) 75 percent for the third year;
- (3) 50 percent for the fourth year; and
- (4) 25 percent for the fifth year.

(j) *Payments to qualifying entities.* Annual incentive payments through cost reports will be made to each hospital that is or is part of a qualifying entity over the 5-year reduction period if the qualifying entity meets the annual and cumulative reduction targets specified in its voluntary reduction plan.

(k) *Penalty for noncompliance—(1) Nonpayment.* No incentive payment may be made to a qualifying entity for a residency training year if the qualifying entity has failed to reduce the number of FTE residents according to its voluntary residency reduction plan.

(2) *Repayment of incentive amounts.* The qualifying entity is liable for repayment of the total amount of incentive payments it has received if the qualifying entity—

(i) Fails to reduce the base number of residents by the percentages specified in paragraphs (g)(2) and (g)(3) of this section by the end of the fifth residency training year; or

(ii) Increases the number of FTE residents above the number of residents permitted under the voluntary residency reduction plan as of the completion date of the plan.

(1) *Postplan determination of FTE caps for qualifying entities—(1) No penalty imposed.* Upon completion of a voluntary residency reduction plan, if no penalty is imposed, the qualifying entity's 1996 FTE count is permanently adjusted to equal the unweighted FTE count used for direct GME payments for the last residency training year in which a qualifying entity participates.

(2) *Penalty imposed.* Upon completion of the voluntary residency reduction plan—

(1) *During repayment period.* If a penalty is imposed under paragraph (k)(2) of this section, during the period of repayment, the qualifying entity's FTE count is as specified in paragraph (1)(1) of this section.

(ii) *After repayment period.* Once the penalty repayment is completed, the qualifying entity's FTE reverts back to its original 1996 FTE cap.

[64 FR 44855, Aug. 18, 1999, as amended at 69 FR 49265, Aug. 11, 2004]

### § 413.89 Bad debts, charity, and courtesy allowances.

(a) *Principle.* Bad debts, charity, and courtesy allowances are deductions from revenue and are not to be included in allowable cost. However, subject to the limitations described under paragraph (h) of this section and the exception for services described under paragraph (i) of this section, bad debts attributable to the deductibles and co-insurance amounts are reimbursable under the program.

(b) *Definitions—(1) Bad debts.* Bad debts are amounts considered to be uncollectible from accounts and notes receivable that were created or acquired in providing services. "Accounts receivable" and "notes receivable" are designations for claims arising from the furnishing of services, and are collectible in money in the relatively near future.

(2) *Charity allowances.* Charity allowances are reductions in charges made by the provider of services because of the indigence or medical indigence of the patient. Cost of free care (uncompensated services) furnished under a Hill-Burton obligation are considered as charity allowances.

(3) *Courtesy allowances.* Courtesy allowances indicate a reduction in charges in the form of an allowance to physicians, clergy, members of religious orders, and others as approved by the governing body of the provider, for services received from the provider. Employee fringe benefits, such as hospitalization and personnel health programs, are not considered to be courtesy allowances.

(c) *Normal accounting treatment: Reduction in revenue.* Bad debts, charity, and courtesy allowances represent reductions in revenue. The failure to collect charges for services furnished does not add to the cost of providing the services. Such costs have already been incurred in the production of the services.

## § 413.89

## 42 CFR Ch. IV (10-1-09 Edition)

(d) *Requirements for Medicare.* Under Medicare, costs of covered services furnished beneficiaries are not to be borne by individuals not covered by the Medicare program, and conversely, costs of services provided for other than beneficiaries are not to be borne by the Medicare program. Uncollected revenue related to services furnished to beneficiaries of the program generally means the provider has not recovered the cost of services covered by that revenue. The failure of beneficiaries to pay the deductible and coinsurance amounts could result in the related costs of covered services being borne by other than Medicare beneficiaries. To assure that such covered service costs are not borne by others, the costs attributable to the deductible and coinsurance amounts that remain unpaid are added to the Medicare share of allowable costs. Bad debts arising from other sources are not allowable costs.

(e) *Criteria for allowable bad debt.* A bad debt must meet the following criteria to be allowable:

(1) The debt must be related to covered services and derived from deductible and coinsurance amounts.

(2) The provider must be able to establish that reasonable collection efforts were made.

(3) The debt was actually uncollectible when claimed as worthless.

(4) Sound business judgment established that there was no likelihood of recovery at any time in the future.

(f) *Charging of bad debts and bad debt recoveries.* The amounts uncollectible from specific beneficiaries are to be charged off as bad debts in the accounting period in which the accounts are deemed to be worthless. In some cases an amount previously written off as a bad debt and allocated to the program may be recovered in a subsequent accounting period; in such cases the income therefrom must be used to reduce the cost of beneficiary services for the period in which the collection is made.

(g) *Charity allowances.* Charity allowances have no relationship to beneficiaries of the Medicare program and are not allowable costs. These charity allowances include the costs of uncompensated services furnished under a Hill-Burton obligation. (Note: In ac-

cordance with section 106(b) of Pub. L. 97-248 (enacted September 3, 1982), this sentence is effective with respect to any costs incurred under Medicare except that it does not apply to costs which have been allowed prior to September 3, 1982, pursuant to a final court order affirmed by a United States Court of Appeals.) The cost to the provider of employee fringe-benefit programs is an allowable element of reimbursement.

(h) *Limitations on bad debts—(1) Hospitals.* In determining reasonable costs for hospitals, the amount of bad debt otherwise treated as allowable costs (as defined in paragraph (e) of this section) is reduced—

(i) For cost reporting periods beginning during fiscal year 1998, by 25 percent;

(ii) For cost reporting periods beginning during fiscal year 1999, by 40 percent;

(iii) For cost reporting periods beginning during fiscal year 2000, by 45 percent; and

(iv) For cost reporting periods beginning during a subsequent fiscal year, by 30 percent.

(2) *Skilled nursing facilities.* For cost reporting periods beginning during fiscal year 2006 or during a subsequent fiscal year, the amount of skilled nursing facility bad debts for coinsurance otherwise treated as allowable costs (as defined in paragraph (e) of this section) for services furnished to a patient who is not a dual eligible individual is reduced by 30 percent. A dual eligible individual is defined for this section as an individual that is entitled to benefits under Part A of Medicare and is determined eligible by the State for medical assistance under Title XIX of the Act as described under paragraph (2) of the definition of a "full-benefit dual eligible individual" at § 423.772 of this chapter.

(i) *Exception.* Bad debts arising from covered services paid under a reasonable charge-based methodology or a fee

**Centers for Medicare & Medicaid Services, HHS****§ 413.98**

schedule are not reimbursable under the program.

[51 FR 34793, Sept. 30, 1986, as amended at 57 FR 33896, July 31, 1992; 60 FR 63189, Dec. 8, 1995; 63 FR 41005, July 31, 1998; 66 FR 32195, June 13, 2001. Redesignated at 69 FR 49254, Aug. 11, 2004, and amended at 71 FR 48142, Aug. 18, 2006; 71 FR 69785, Dec. 1, 2006]

**§ 413.90 Research costs.**

(a) *Principle.* Costs incurred for research purposes, over and above usual patient care, are not includable as allowable costs.

(b) *Application.* (1) There are numerous sources of financing for health-related research activities. Funds for this purpose are provided under many Federal programs and by other tax-supported agencies. Also, many foundations, voluntary health agencies, and other private organizations, as well as individuals, sponsor or contribute to the support of medical and related research. Funds available from such sources are generally ample to meet basic medical and hospital research needs. A further consideration is that quality review should be assured as a condition of governmental support for research. Provisions for such review would introduce special difficulties in the Medicare programs.

(2) If research is conducted in conjunction with, and as a part of, the care of patients, the costs of usual patient care and studies, analyses, surveys, and related activities to serve the provider's administrative and program needs are allowable costs in the determination of payment under Medicare.

[51 FR 34793, Sept. 30, 1986, as amended at 61 FR 63748, Dec. 2, 1996]

**§ 413.92 Costs of surety bonds.**

Costs incurred by a provider to obtain a surety bond required by part 489, subpart F of this chapter are not included as allowable costs.

[63 FR 310, Jan. 5, 1998]

**§ 413.94 Value of services of nonpaid workers.**

(a) *Principle.* The value of services in positions customarily held by full-time employees performed on a regular, scheduled basis by individuals as nonpaid members of organizations

under arrangements between such organizations and a provider for the performance of such services without direct remuneration from the provider to such individuals is allowable as an operating expense for the determination of allowable cost subject to the limitation contained in paragraph (b) of this section. The amounts allowed are not to exceed those paid others for similar work. Such amounts must be identifiable in the records of the institutions as a legal obligation for operating expenses.

(b) *Limitations: Services of nonpaid workers.* The services must be performed on a regular, scheduled basis in positions customarily held by full-time employees and necessary to enable the provider to carry out the functions of normal patient care and operation of the institution. The value of services of a type for which providers generally do not remunerate individuals performing such services is not allowable as a reimbursable cost under the Medicare program. For example, donated services of individuals in distributing books and magazines to patients, or in serving in a provider canteen or cafeteria or in a provider gift shop, would not be reimbursable.

(c) *Application.* The following illustrates how a provider would determine an amount to be allowed under this principle: The prevailing salary for a lay nurse working in Hospital A is \$5,000 for the year. The lay nurse receives no maintenance or special perquisites. A sister working as a nurse engaged in the same activities in the same hospital receives maintenance and special perquisites which cost the hospital \$2,000 and are included in the hospital's allowable operating costs. The hospital would then include in its records an additional \$3,000 to bring the value of the services rendered to \$5,000. The amount of \$3,000 would be allowable if the provider assumes obligation for the expense under a written agreement with the sisterhood or other religious order covering payment by the provider for the services.

**§ 413.98 Purchase discounts and allowances, and refunds of expenses.**

(a) *Principle.* Discounts and allowances received on purchases of goods or