

§413.17

reimbursable costs (§413.30) or the ceiling on the rate of hospital cost increases (§413.40).

(ii) *Reimbursement as a result of carry-over.* The new provider is reimbursed for the costs that are carried forward to a succeeding cost reporting period—

(A) If total charges for the services provided in that subsequent period exceed the total reasonable cost of the services; and

(B) To the extent that accumulation of the costs being carried forward and the costs for the services provided in that subsequent period do not exceed the customary charges for those services.

(iii) *Five succeeding periods less than 60 months.* If the five succeeding cost reporting periods are less than 60 full calendar months, the provider may carry forward the unreimbursed costs for one additional cost reporting period.

(iv) *Example.* A provider begins its operations on March 5, 1972. However, it begins to participate in the Medicare program as of January 1, 1973, and reports on a calendar year basis. Because the provider would be subject to the lesser of cost or charges principle for its cost reporting period beginning with January 1, 1974, it would be permitted to accumulate any unreimbursed costs (excess of costs over its charges) incurred during this reporting period. Therefore, because this cost reporting period ends before the end of the third year of operation, its carry-over period would be the succeeding five cost reporting periods ending with December 31, 1979. If this provider had begun its operation on July 1, 1973, and become a participating provider as of the same date (with a fiscal year ending June 30), it would have been able to accumulate any unreimbursed costs for the two cost reporting periods ending June 30, 1975, and June 30, 1976. Its carry-over period would then be the five cost reporting periods ending no later than June 30, 1981, in the case of costs unreimbursed in either of the reporting

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periods ending June 30, 1975, or June 30, 1976.

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§413.17 Cost to related organizations.

(a) *Principle.* Except as provided in paragraph (d) of this section, costs applicable to services, facilities, and supplies furnished to the provider by organizations related to the provider by common ownership or control are includable in the allowable cost of the provider at the cost to the related organization. However, such cost must not exceed the price of comparable services, facilities, or supplies that could be purchased elsewhere.

(b) *Definitions.* (1) *Related to the provider.* Related to the provider means that the provider to a significant extent is associated or affiliated with or has control of or is controlled by the organization furnishing the services, facilities, or supplies.

(2) *Common ownership.* Common ownership exists if an individual or individuals possess significant ownership or equity in the provider and the institution or organization serving the provider.

(3) *Control.* Control exists if an individual or an organization has the power, directly or indirectly, significantly to influence or direct the actions or policies of an organization or institution.

(c) *Application.* (1) Individuals and organizations associate with others for various reasons and by various means. Some deem it appropriate to do so to assure a steady flow of supplies or services, to reduce competition, to gain a tax advantage, to extend influence, and for other reasons. These goals may be accomplished by means of ownership or control, by financial assistance, by management assistance, and other ways.

(2) If the provider obtains items of services, facilities, or supplies from an

organization, even though it is a separate legal entity, and the organization is owned or controlled by the owner(s) of the provider, in effect the items are obtained from itself. An example would be a corporation building a hospital or a nursing home and then leasing it to another corporation controlled by the owner. Therefore, reimbursable cost should include the costs for these items at the cost to the supplying organization. However, if the price in the open market for comparable services, facilities, or supplies is lower than the cost to the supplier, the allowable cost to the provider may not exceed the market price.

(d) *Exception.* (1) An exception is provided to this general principle if the provider demonstrates by convincing evidence to the satisfaction of the fiscal intermediary (or, if the provider has not nominated a fiscal intermediary, HCFA), that—

(i) The supplying organization is a bona fide separate organization;

(ii) A substantial part of its business activity of the type carried on with the provider is transacted with others than the provider and organizations related to the supplier by common ownership or control and there is an open, competitive market for the type of services, facilities, or supplies furnished by the organization;

(iii) The services, facilities, or supplies are those that commonly are obtained by institutions such as the provider from other organizations and are not a basic element of patient care ordinarily furnished directly to patients by such institutions; and

(iv) The charge to the provider is in line with the charge for such services, facilities, or supplies in the open market and no more than the charge made under comparable circumstances to others by the organization for such services, facilities, or supplies.

(2) In such cases, the charge by the supplier to the provider for such services, facilities, or supplies is allowable as cost.

Subpart B—Accounting Records and Reports

§ 413.20 Financial data and reports.

(a) *General.* The principles of cost reimbursement require that providers maintain sufficient financial records and statistical data for proper determination of costs payable under the program. Standardized definitions, accounting, statistics, and reporting practices that are widely accepted in the hospital and related fields are followed. Changes in these practices and systems will not be required in order to determine costs payable under the principles of reimbursement. Essentially the methods of determining costs payable under Medicare involve making use of data available from the institution's basis accounts, as usually maintained, to arrive at equitable and proper payment for services to beneficiaries.

(b) *Frequency of cost reports.* Cost reports are required from providers on an annual basis with reporting periods based on the provider's accounting year. In the interpretation and application of the principles of reimbursement, the fiscal intermediaries will be 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