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(2) Amounts included in rentals or lease payments for repair or maintenance agreements.

(3) Interest expense incurred to borrow working capital (for operating expenses).

(4) General liability insurance or any other form of insurance to provide protection other than for the replacement of depreciable assets or to pay capital-related costs in the case of business interruption.

(5) Taxes other than those assessed on the basis of some valuation of land or depreciable assets used for patient care. (Taxes not related to patient care, such as income taxes, are not allowable, and are therefore not included among either capital-related or operating costs.)

(6) The costs of minor equipment that are charged off to expense rather than capitalized as described in paragraph (d) of this section.

(7) The costs incurred for maintenance and repair insurance agreements (commonly referred to as maintenance agreements).

(j) *Reduction to capital-related costs.* (1) Except for sole community hospitals and critical access hospitals, the amount of capital-related costs of all hospital outpatient services is reduced by—

(i) 15 percent for portions of cost reporting periods occurring on or after October 1, 1989, through September 30, 1991; and

(ii) 10 percent for portions of cost reporting periods occurring on or after October 1, 1991 and until the first date that the prospective payment system under part 419 of this chapter is implemented.

(2) For purposes of determining the blended payment amounts for hospital outpatient services under §413.118 and §413.122, the reduction is applicable only to the hospital-specific portion of the blended amounts.

[51 FR 34793, Sept. 30, 1986, as amended at 52 FR 21225, June 4, 1987; 56 FR 43456, Aug. 30, 1991; 57 FR 3017, Jan. 27, 1992; 57 FR 36017, Aug. 12, 1992; 57 FR 43917, Sept. 23, 1992; 58 FR 17528, Apr. 5, 1993; 59 FR 26960, May 25, 1994; 62 FR 46037, Aug. 29, 1997; 65 FR 18542, Apr. 7, 2000]

§413.134 Depreciation: Allowance for depreciation based on asset costs.

(a) *Principle.* An appropriate allowance for depreciation on buildings and equipment used in the provision of patient care is an allowable cost. The depreciation must be—

(1) Identifiable and recorded in the provider's accounting records;

(2) Based on the historical cost of the asset, except as specified in paragraph (j) of this section regarding donated assets; and

(3) Prorated over the estimated useful life of the asset using—

(i) The straight-line method; or

(ii) Accelerated depreciation under a declining balance method (not to exceed double the straight-line rate) or the sum-of-the-years' digits method in the following situations:

(A) Depreciable assets for which accelerated depreciation was used for Medicare purposes before August 1, 1970, including those assets for which a timely request to change from straight-line depreciation to accelerated depreciation was received by an intermediary before August 1, 1970;

(B) Depreciable assets acquired before August 1, 1970, if no election to use straight-line or accelerated depreciation was in effect on August 1, 1970, and the provider was participating in the program on August 1, 1970;

(C) Depreciable assets of a provider if construction of such depreciable asset began before February 5, 1970, and the provider was participating in the program on February 5, 1970; or

(D) Depreciable assets of a provider if a valid written contract was entered into by a provider participating in the program before February 5, 1970, for construction, acquisition, or for the permanent financing thereof, and such contract was binding on a provider on February 5, 1970, and at all times thereafter; or

(iii) A declining balance method, not to exceed 150 percent of the straight-line rate, for a depreciable asset acquired after July 31, 1970; however, this declining balance method may be used only if the cash flow from depreciation on the total assets of the institution 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 debts related to the provider's total depreciable assets. For each depreciable asset for which a provider requests authorization to use a declining balance method for Medicare reimbursement purposes, but 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 in which 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 this accelerated depreciation or making its reasonable cost determination which includes an allowance for such depreciation.

(b) *General rules*—(1) *Historical cost*. Historical cost is the cost incurred by the present owner in acquiring the asset.

(i) *All providers*—(A) *Depreciable assets acquired after July 31, 1970 and before December 1, 1997*. For depreciable assets acquired after July 31, 1970 and before December 1, 1997, and for a hospital or an SNF, acquired before July 18, 1984, the historical cost may not exceed the lower of 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 of the asset at the time of its purchase.

(B) *Depreciable assets acquired on or after December 1, 1997*. For depreciable assets acquired on or after December 1, 1997, the historical cost of the asset that will be recognized under this program must not exceed 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). For this paragraph (b)(1)(i)(B), 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 acquisition cost to the owner of record is subject to the limitation on historical costs described in paragraphs (g) (1), (2), and (3) 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 §§413.153(d) and 413.157(b) for application of the limitation to the cost of land for purposes of determining the allowable interest expense.)

(3) Acquisition cost to the owner of record includes the costs of betterment or improvements that extend the estimated useful life of an asset at least 2 years beyond its original estimated useful life or that increase the productivity of an asset significantly over its original productivity.

(4) For assets acquired prior to a provider's entrance into the Medicare program, the acquisition 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 acquisition cost to the owner of record is the historical cost established for those assets when the provider changed to actual depreciation as described in §413.139(e). If the provider did not change to actual depreciation, as described in §413.139(e), for optional allowance assets, the acquisition 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 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 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 paragraph (f)(2)(iv) of this section), legal fees, accounting

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and administrative costs, travel costs, and the costs of feasibility studies.

(ii) *Hospitals and SNFs only.* (A) For assets acquired on or after July 18, 1984 and before December 1, 1997 and not subject to an enforceable agreement entered into before July 18, 1984, historical cost may not exceed the lowest of the following:

(1) The allowable acquisition cost 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.

(B) For purposes of applying paragraph (b)(1)(ii)(A) of this section, 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.

(C) The acquisition cost to the owner of record is subject to any limitation on historical costs described in paragraphs (b)(1)(i) or (g)(1) and (2) of this section, and is not reduced by any depreciation taken by the owner of record. This limitation on historical cost is also applied to the purchase of land, a capital asset that is neither depreciable nor amortizable under any circumstances. (See §§413.153(d) and 413.157(b) for application of the limitation to the cost of land for purposes of determining allowable interest expense and return on equity capital or proprietary providers.)

(D) Acquisition cost to the owner of record includes the costs of betterments or improvements that extend the estimated useful life of an asset at least two years beyond its original estimated useful life or increase the productivity of an asset significantly over its original productivity.

(E) For assets acquired prior to a hospital's or SNF's entrance into the Medicare program, the acquisition cost to the owner of record is the historical cost of the asset when acquired, rather than when the hospital or SNF entered the program.

(F) For assets subject to the optional depreciation allowance as described in

§413.139, the acquisition cost to the owner of record is the historical cost established for those assets when the hospital or SNF changed to actual depreciation as described in §413.139(e). If the hospital or SNF did not change to actual depreciation, as described in §413.139(e), 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.

(G) The historical cost of an asset acquired on or after July 18, 1984 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 paragraph (f)(2)(iv) of this section), legal fees, accounting and administrative costs, travel costs, and the costs of feasibility studies.

(iii) *Hospital-based providers other than SNFs and SNF-based providers.* For changes of ownership that involve assets of a hospital-based provider other than a SNF, or assets of a SNF-based provider, the provisions of paragraph (b)(1)(ii) of this section are not applicable. A reasonable allocation of the purchase price must be made, so that the hospital-based provider other than a SNF, or a SNF-based provider, is not affected by the limitations described in paragraph (b)(1)(ii) of this section. The historical cost of assets of providers other than hospitals and SNFs is governed by paragraph (b)(1)(i) of this section.

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

(3) *The straight-line method.* Under the straight-line method of depreciation, the cost or other basis (for example, fair market value in the case of donated assets) of the asset, less its estimated salvage value, if any, is determined first. Then this amount is distributed in equal amounts over the period of the estimated useful life of the asset.

(4) *Declining balance method.* Under the declining balance method, the annual depreciation allowance is computed by multiplying the undepreciated cost of the asset each year by a uniform rate up to double the straight-line rate or 150 percent, as the case may be (see paragraph (a)(3) of this section for limitations on use of accelerated methods of depreciation).

(5) *Sum-of-the-years' digits method.* Under the sum-of-the-years' digits method, the annual depreciation allowance is computed by multiplying the depreciable cost basis (cost less salvage value) by a constantly decreasing fraction. The numerator of the fraction is represented by the remaining years of useful life of the asset at the beginning of each year, and the denominator is always represented by the sum of the years' digits of useful life at the time of acquisition.

(6) *Current reproduction cost.* Current reproduction cost is the cost at current prices, in a particular locality or market area, of reproducing an item of property or a group of assets. Where depreciable assets are concerned, this means the reasonable cost to have built, reproduce in kind, or, in the case of equipment or similar assets, to purchase in the competitive market.

(7) *Useful life.* The estimated useful life of a depreciable asset is its normal operating or service life to the provider, subject to the provisions in paragraph (b)(7)(i) of this section. Factors to be considered in determining useful life 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.

(i) *Initial selection of useful life.* In selecting a proper useful life for computing depreciation under the Medicare program, providers must use the useful

life guidelines published by CMS. If CMS has not published applicable useful life guidelines, providers must use—

(A) The edition of the American Hospital Association useful life guidelines, as specified in CMS Medicare program manuals; or

(B) A different useful life specifically requested by the provider and approved by the intermediary. A different useful life may be approved by the intermediary if the provider's request is properly supported by acceptable factors that affect the determination of useful life. However, such factors as an expected early sale, retirement, demolition or abandonment of an asset, or termination of the provider from the Medicare program may not be used.

(ii) *Application of guidelines.* The provisions concerning the selection of useful life guidelines described in paragraph (b)(7)(i) of this section apply to assets acquired on or after January 1, 1981. For assets acquired before January 1, 1981, providers must use the useful life guidelines published by the American Hospital Association in its 1973 edition of *Chart of Accounts for Hospitals*, or those published by the Internal Revenue Service, or those approved for use by intermediaries as provided in paragraph (b)(7)(i)(B) of this section.

(iii) *Changing useful life.* A change in the estimated useful life may be made if clear and convincing evidence justifies a redetermination of the useful life used by the provider. Such a change must be approved by the intermediary in writing, and the factors cited in paragraphs (b)(7) and (b)(7)(i) of this section are applicable in making such redeterminations of useful life. If the request is approved, the change is effective with the reporting period immediately following the period in which the provider's request is submitted for approval.

(8) *Donated asset.* An asset is considered donated when the provider acquires the asset without making payment in the form of cash, new debt, assumed debt, property or services. Except as provided in paragraph (j)(3) of this section, if a provider makes payment in any form to acquire an asset, the payment is considered the purchase

price for the purpose of determining allowable historical cost.

(9) *Net book value.* The net book value of an asset is the depreciable basis used for the Medicare program by the asset's last participating owner less depreciation recognized under the Medicare program.

(c) *Recording of depreciation.* Appropriate recording of depreciation includes the identification of the depreciable assets in use, the assets' historical costs, the assets' dates of acquisition, the method of depreciation, estimated useful lives, and the assets' accumulated depreciation.

(d) *Depreciation methods*—(1) *General.* Proration of the cost of an asset over its useful life is allowed on the straight-line method, or, when permitted under paragraph (a)(3) of this section, the declining balance or the sum-of-the-years' digits methods. One method may be used on a single asset or group of assets and another method on others. In applying the declining balance or sum-of-the-years' digits method to an asset that is not new, the undepreciated cost of the asset is treated as the cost of a new asset in computing depreciation.

(2) *Change in method.* Prior to August 1, 1970, a provider may change from the straight-line method to an accelerated method or vice versa, upon advance approval from the intermediary on a prospective basis with the request being made before the end of the first month of the prospective reporting period. Only one such change with respect to a particular asset may be made by a provider. Effective with August 1, 1970, a provider may only change from an accelerated method or optional method (see §413.139) to the straight-line method. Such a change may be made without intermediary approval and the basis for depreciation is the undepreciated cost reduced by the salvage value. Thereafter, once straight-line depreciation is selected for a particular asset, an accelerated method may not be established for that asset.

(3) *Recovery of accelerated depreciation*—(i) *General.* If a provider who has used an accelerated method of depreciation for any of its assets terminates participation in the program, or if the Medicare proportion of its allowable

costs decreases so that cumulatively substantially more depreciation was paid than would have been paid using the straight-line method of depreciation, the excess of reimbursable cost determined by using accelerated depreciation methods and paid under the program over the reimbursable cost that would have been determined and paid under the program by using the straight-line method of depreciation, will be recovered as an offset to current reimbursement due or, if the provider has terminated participation in the program, as an overpayment. In this determination of excess payment, recognition will be given to the effects the adjustment to straight-line depreciation would have on the return on equity capital and on the allowance in lieu of specific recognition of other costs in the respective years.

(ii) *Transaction between related organizations*—(A) *General.* If the termination of the provider agreement is due to a change in provider ownership, as defined in §489.18 of this chapter, resulting from a transaction between related organizations, as defined in §413.17, and the criteria in paragraph (b) of this section are met, the excess of reimbursable cost, as determined in paragraph (d)(3)(i) of this section may not be recovered if there is a continuation of participation by the facility in the Medicare program.

(B) *Criteria.* The following criteria must be met if the recovery of excess reimbursable cost is not to be made:

(1) The termination of the provider agreement is due to a change in ownership of the provider resulting from a transaction between related organizations.

(2) The successor provider continues to participate in the Medicare program.

(3) Control and the extent of the financial interest of the owners of the provider before and after the termination remain the same; that is, the successor owners acquire the same percentage of control or financial investment as the transferors had.

(4) All assets and liabilities of the terminated provider are transferred to the related successor participating provider.

(C) *Effect of transaction.* In transactions meeting the criteria specified in paragraph (d)(3)(ii)(B) of this section, the provision concerning recovery of excess reimbursable cost (§413.134(d)(3)(i)) is not applied, and the transaction is treated as follows:

(1) The successor provider must record the historical cost and accumulated depreciation and the method of depreciation recognized under the Medicare program, and these are considered as incurred by the successor provider for Medicare purposes.

(2) The Medicare program's utilization of the terminated provider is considered as having been incurred by the successor provider for Medicare purposes.

(3) The equity capital of the terminated provider as of the closing of its final cost reporting period must be wholly contained in the equity capital of the successor provider as of the beginning of its first cost reporting period.

(e) *Funding of depreciation.* Although funding of depreciation is not required, it is strongly recommended that providers use this mechanism as a means of conserving funds for replacement of depreciable assets. Funded depreciation account funds must be placed in readily marketable investments of the type that assures the availability and conservation of the funds. Additions to the funded depreciation account must remain in the account for at least 6 months to be considered valid funding transactions.

(1) *Incentive.* As an incentive for funding, investment income on funded depreciation is not treated as a reduction of allowable interest expense provided such investment income is deposited in, and becomes part of, the funded depreciation account at the time of receipt by the provider. Investment income earned on deposits before the 6-month period elapses are not offset unless the deposits are withdrawn for an improper purpose during this period. If a provider transfers assets of the funded depreciation account to a related organization (for example, pooling of several chain organization providers' funded depreciation accounts at the chain home office for investment purposes), these assets shall be treated as the pro-

vider's funds and are subject to all the requirements specified in paragraph (e) of this section.

(2) *Availability of funded depreciation.* (i) CMS considers funded depreciation available for use in the acquisition or replacement of depreciable assets related to patient care unless the funded depreciation funds have been committed by contract for the acquisition of depreciable assets related to the furnishing of patient care or for other capital purposes related to patient care.

(ii) Borrowing for a purpose for which funded depreciation account funds should have been used makes the borrowing unnecessary to the extent that funded depreciation account funds were available at the time of the borrowing. Available funds in the funded depreciation account, to the extent of the unnecessary borrowing, are called "tainted" funds. Interest expense incurred on borrowing for a capital purpose is not an allowable cost to the extent that funded depreciation account funds were available at the time of the borrowing.

(iii) A provider can remove the "unnecessary" characterization of borrowing, and thereby cure tainted funded depreciation, by using the tainted funds for a proper purpose described in paragraph (e)(3)(i) of this section. However, any funded depreciation that existed at the time of the unnecessary borrowing and is not classified as tainted must be used before any of the tainted funds.

(iv) When only a portion of the borrowing is considered unnecessary under paragraph (e)(2)(ii) of this section, subsequent repayments of such borrowing from general funds are applied first to the allowable portion of the borrowing and then, when all of the allowable borrowing is repaid, to the unallowable portion of the borrowing. When funds from the funded depreciation account are used for the repayment of the unnecessary borrowing, an equivalent amount of tainted funds is cured without regard to the provisions of paragraphs (e)(2)(ii) and (e)(3)(i)(C) of this section. Similarly, where general funds are used to pay for the unallowable borrowing after the necessary borrowing has been repaid, an equivalent amount of tainted funded depreciation

is cured without regard to the provisions of paragraphs (e)(2)(ii) and (e)(3)(i)(C) of this section.

(3) *Withdrawals of funded depreciation*—(i) *Proper withdrawals.* (A) Withdrawals from funded depreciation are considered proper if made either for the acquisition or replacement of depreciable assets related to the furnishing of patient care or for other capital purposes related to patient care.

(B) *First-in, first-out basis.* Proper withdrawals from funded depreciation are made on a first-in, first-out basis.

(C) *Exception.* If CMS determines that a borrowing is unnecessary because of the existence of available funded depreciation, and additional deposits have been made to funded depreciation after the occurrence of the unnecessary borrowing, withdrawals made after the date of the additional deposits are deemed to be made on a last-in, first-out basis.

(ii) *Improper withdrawals.* (A) Withdrawals from funded depreciation that do not meet the requirements for proper withdrawals under the provisions in paragraph (e)(3)(i)(A) of this section are considered improper withdrawals.

(B) Improper withdrawals from funded depreciation are made on a last-in, first-out basis. If improper withdrawals are made, interest expense is reduced in accordance with section §413.153(c)(3).

(C) Improper withdrawals will result in the offset of otherwise allowable interest expense under the offset provisions in §413.153(c)(3).

(4) *Loans from funded depreciation.* (i) When the general fund of the provider borrows from the funded depreciation to obtain working capital for normal operating expenses to furnish patient care, interest incurred by the general fund is an allowable operating cost only if the interest expense is supported by documents that evidence that the funds were borrowed and that payment of interest and repayment of the funds are required, is separately identified in the provider's accounting records, and meets the necessary and proper tests described in §§413.153(b)(2) and (b)(3). However, if the general fund of the provider borrows from the funded depreciation account to acquire depreciable assets used in furnishing pa-

tient care, or for other capital purposes related to patient care, interest expense paid by the general fund to the funded depreciation account is not an allowable cost. Providers are expected to use the funded depreciation for these purposes.

(ii) Loans from funded depreciation to the general fund are considered investments of funded depreciation, but do not have to meet the readily marketable test described in paragraph (e) of this section. Loans made from funded depreciation are subject to the requirement that funded depreciation must be available for the acquisition of depreciable assets used to furnish patient care, or for other capital purposes related to patient care. Costs incurred to secure lines of credit from lending institutions to ensure such availability are not allowable costs.

(iii) Funding of depreciation from general funds will not be recognized to the extent of any outstanding loans from the funded depreciation account to the general fund. Deposits from the general fund into the funded depreciation account must be first applied to reduce any loans outstanding from the funded depreciation to the general fund. When the loans are repaid in full, general funds deposited in the funded depreciation account are considered as repayments of the general fund. Therefore, any subsequent interest expense of the general fund paid to the funded depreciation fund is not an allowable cost.

(iv) A provider may loan its funded depreciation to a related organization for any purpose subject to the following conditions:

(A) Authorization for such a loan by the provider's appropriate managing body of the provider, such as Board of Trustees or Board of Directors, must be on file.

(B) The funded depreciation loaned must remain available, as specified in paragraph (e)(2) of this section, to the provider making the loan. Costs incurred for lines of credit to assure such availability are not allowable costs. During the period of time that the loan is outstanding, if the provider making the loan resorts to outside borrowing

for a purpose for which its funded depreciation should have been used, interest expense on an amount of the outside borrowing up to the amount of the funded depreciation that should have been available would be disallowed as unnecessary.

(C) Such loans shall be considered investments of the provider's funded depreciation, but the requirement that funded depreciation be invested in readily marketable investments as required in paragraph (e) of this section is waived for such loans.

(D) The funded depreciation account must earn interest on such loans at a rate that does not exceed the rate that would be charged for a comparable loan from an independent lending institution. This investment income will not be used to reduce the provider's interest expense if all the other conditions in paragraph (e) of this section are met. If the entity borrowing the funds is another provider participating in the Medicare program, the interest expense incurred on such loans would be allowable if the loan meets all of the interest expense requirements specified in §413.153. (For purposes of §413.153(b)(3)(ii), such loans are not considered to be with a related lender.)

(f) *Gains and losses on disposal of assets*—(1) *General.* Depreciable assets may be disposed of through sale, scrapping, trade-in, exchange, demolition, abandonment, condemnation, fire, theft, or other casualty. If disposal of a depreciable asset, including the sale or scrapping of an asset before December 1, 1997, results in a gain or loss, an adjustment is necessary in the provider's allowable cost. (No gain or loss is recognized on either the sale or the scrapping of an asset that occurs on or after December 1, 1997.) The amount of a gain included in the determination of allowable cost is limited to the amount of depreciation previously included in Medicare allowable costs. The amount of a loss to be included is limited to the undepreciated basis of the asset permitted under the program. The treatment of the gain or loss depends upon the manner of disposition of the asset, as specified in paragraphs (f)(2) through (6) of this section. The gain or loss on the disposition of depreciable assets has no retroactive effect on a propri-

etary provider's equity capital for years prior to the year of disposition.

(2) *Bona fide sale or scrapping before December 1, 1997.* For the bona fide sale or scrapping of depreciable assets before December 1, 1997, the following apply:

(i) Except as specified in paragraph (f)(3) of this section, gains and losses realized from the bona fide sale or scrapping of depreciable assets are included in the determination of allowable cost only if the sale or scrapping occurs while the provider is participating in Medicare. The extent to which such gains and losses are included is calculated by prorating the basis for depreciation of the asset in accordance with the proportion of the asset's useful life for which the provider participated in Medicare. For purposes of this paragraph (f)(2)(i), scrapping refers to the physical removal from the provider's premises of tangible personal properties that are no longer useful for their intended purpose and are only salable for their scrap or junk value.

(ii) If the total amount of gains or losses realized from bona fide sales or scrapping does not exceed \$5,000 within the cost reporting period or if the provider's cumulative utilization under the Medicare program is less than 5 percent, the net amount of gains or losses realized from sale or scrapping will be allowed as a depreciation adjustment in the period of disposal. For purposes of this paragraph (f)(2)(ii), the provider's cumulative Medicare utilization percentage is determined by comparing the cumulative total of the Medicare inpatient days for all reporting periods in which depreciation on the asset disposed of was claimed under the Medicare program to the cumulative total of inpatient days of the participating provider for the same reporting periods.

(iii) If the conditions specified in paragraph (f)(2)(ii) of this section are not met, the adjustment to reimbursable cost in the reporting period of asset disposition is calculated as follows:

(A) The total amount of gains or losses shall be allocated to all reporting periods under the Medicare program, based on the ratio of the depreciation allowed on the assets in each reporting period to the total depreciation allowed under the Medicare program.

(B) The results of this allocation are multiplied by the ratio of Medicare reimbursable cost to total allowable cost for each reporting period.

(C) The results of this multiplication are then added.

(D) Effective for cost reporting periods beginning on or after October 1, 1991, no adjustment will be made for the portion of gains or losses allocated to inpatient hospital services for which the hospital was paid under the fully prospective payment methodology as described in § 412.340 of this chapter or under the hold-harmless methodology based on the Federal rate as described in § 412.344(a)(1) of this chapter for new capital costs or in § 412.344(a)(2) of this chapter.

(iv) If a provider sells more than one asset for a lump sum sales price, the gain or loss on the sale of each depreciable asset must be determined by allocating the lump sum sales price among all the assets sold, 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 sales 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 will require an appraisal by an independent appraisal expert to establish the fair market value of each asset and will make an allocation of the sales price in accordance with the appraisal.

(3) *Sale within 1 year after termination.* Gains and losses realized from a bona fide sale of depreciable assets within 1 year immediately following the date on which the provider terminates participation in the Medicare program are also included in the determination of allowable cost, in accordance with the procedure specified in paragraph (f)(2) of this section. However, if several assets are sold for a lump sum sales price, the determination of fair market

value must be based on the appraised value of the assets as they were last used by the provider while participating in the Medicare program.

(4) *Exchange, trade-in or donation.* Gains or losses realized from the exchange, trade-in, or donation of depreciable assets are not included in the determination of allowable cost. When the disposition of an asset is by means of exchange or trade-in, the historical cost of the new asset is the sum of the undepreciated cost of the asset disposed of and the additional 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) exceed 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.

(5) *Demolition or abandonment.* (i) For purposes of this section, the term "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 Medicare 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.

(ii) If losses resulting from the demolition or abandonment of depreciable assets do not exceed \$5,000 within the cost-reporting period, the losses are to be allowed in the period of disposal.

(iii) If losses exceed \$5,000 and, at the date of disposition, the demolished or abandoned assets are at least 80 percent depreciated as computed under the straight-line method, such losses are includable in the determination of allowable cost under the Medicare program in the period of disposal and the procedure provided in paragraph (f)(2)(iii) of this section must be used in determining the adjustment to reimbursable cost.

(iv) Losses in excess of \$5,000 resulting from the demolition or abandonment of assets, which at the date of

disposition are not 80 percent depreciated as computed under the straight-line method, must be capitalized as a deferred charge and amortized as follows:

(A) If the State Health Planning and Development Agency (SHPDA) designated under section 1521 of the Public Health Service Act approves the demolition or abandonment of a depreciable asset as being consistent with the health systems plan of the health service area in which the provider is located, the net loss realized shall be capitalized as a deferred charge and amortized over the remaining life of the demolished or abandoned asset, or at the rate of \$5,000 per year, whichever is greater. If no SHPDA exists or if such agency is unable or unwilling to perform this function, the provider must submit a request for approval to the intermediary. The intermediary, after reviewing this request and before issuing the approval, will submit the request along with its recommendation to the appropriate Regional Office for its approval.

(B) If a provider fails to obtain approval as specified in paragraph (f)(5)(iv)(A) of this section, a loss is not allowable unless the demolished or abandoned asset is replaced. If the asset is replaced, the loss resulting from the unapproved demolition or abandonment must be capitalized as a deferred charge and amortized over the estimated useful life of the replacement asset or at the rate of \$5,000 per year, whichever is greater.

(v) If a loss resulting from the demolition or abandonment is deferred and amortized and the provider terminates its participation in the Medicare program or ceases to use a replacement asset in the provision of patient care services, the unamortized deferred charge remaining at that time must not be included in determining allowable cost under the Medicare program.

(vi) Losses on demolition must include the demolition cost incurred by the provider for razing and removal of the asset, less any salvage value recovered by the provider. However, if a provider demolishes a depreciable asset for the purpose of preparing land for future sale, the net demolition cost incurred by the provider (razing and removal

costs less salvage recovered) is considered a capital expenditure and added to the historical basis of the land.

(vii) If a provider purchases land on which there is a building, no depreciation will be allowed under the Medicare program unless the building is used in providing patient care. If the building is demolished, the entire purchase price and demolition cost shall be considered the historical cost of the land. If the building is used for patient care, but demolished within 5 years of purchase, the entire purchase price, less allowed depreciation, plus demolition cost will be considered the historical cost of the land.

(6) *Involuntary conversion.* (i) Losses resulting from the involuntary conversion of depreciable assets, such as condemnation, fire, theft, or other casualty, are generally included in the determination of allowable cost on a deferred basis if the asset is restored or replaced. However, losses resulting from a provider's imprudent management of its depreciable assets, such as the failure to obtain proper insurance coverage, are not included in the determination of allowable cost.

(ii) The net allowable loss from involuntary conversion must consist of the undepreciated cost of unrecovered book value of the asset, less amounts received from insurance proceeds gifts, and grants received from local, State, or Federal government, or any other source as a result of the involuntary conversion.

(iii) If the asset is replaced and the net allowable loss in any cost-reporting period does not exceed \$5,000, the entire amount must be included in allowable cost in the period in which the loss is incurred. If the asset is replaced and the net allowable loss in any cost-reporting period exceeds \$5,000, the loss must be capitalized as a deferred charge and amortized over the useful life of the replacement or restored asset. If a replaced or restored asset ceases to be used in the provision of patient care services or the provider terminates its participation in the Medicare program, the unamortized deferred charge remaining at that time will not be included in determining allowable cost under the Medicare program.

(iv) If the provider fails to replace or restore an involuntarily converted asset, the loss is not included in determining allowable cost. However, if the provider intends to replace or restore the asset but is unable to do so because the designated SHPDA finds such replacement or restoration to be inconsistent with the health systems plan of the provider's health service area, the loss is allowable so long as the provider continues to participate in Medicare. In this case, the loss must be capitalized as a deferred charge and amortized over the remaining life of the involuntarily converted asset, or at the rate of \$5,000 per year, whichever is greater.

(v) If a gain is realized from an involuntary conversion of depreciable assets, the net amount realized reduces the basis of the restored or replacement asset. If the asset is not restored or replaced, the gain is to be treated in accordance with paragraph (f)(2) of this section.

(7) *Effect on equity capital.* The unrecovered loss entered on the books of the provider as a deferred charge, in accordance with paragraphs (f) (5) and (6) of this section, is not includable in the computation of equity capital under §413.157.

(8) *Sale of replacement or restored assets.* If a provider sells a replacement or restored asset while participating in the Medicare program or within 1 year immediately following the date on which it terminates its participation in the Medicare program, the unrecovered loss entered on the books of the provider as a deferred charge in accordance with paragraphs (f) (5) and (6) of this section will not be included in determining the gain or loss realized from the sale of the replacement or restored asset. However, if the sale of such asset is made to a related organization, as defined in §413.17, and the purchasing organization continues as a provider in the Medicare program, the remaining deferred charge representing the unrecovered depreciable basis of the demolished, abandoned or destroyed asset must continue to be amortized over the remaining expected useful life of the replacement or restored asset. If the sale is made to an unrelated organization, further amorti-

zation of the deferred charge is not allowed.

(g) *Establishment of cost basis on purchase of facility as an ongoing operation—*(1) *Assets acquired after July 1, 1966 and before August 1, 1970.* The cost basis for the assets of a facility purchased as an ongoing operation after July 1, 1966, and before August 1, 1970, is the lowest of the—

(i) Total price paid for the facility by the purchaser, as allocated to the individual assets of the facility;

(ii) Total fair market value of the facility at the time of the sale, as allocated to the individual assets; or

(iii) Combined fair market value of the individually identified assets at the time of the sale.

(2) *Assets acquired after July 31, 1970 and, for hospitals and SNFs, before July 18, 1984.* For depreciable assets acquired after July 31, 1970 and, for hospitals and SNFs, before July 18, 1984, in addition to the limitations specified in paragraph (g)(1) of this section, the cost basis of the depreciable assets may not exceed the current reproduction cost depreciated on a straight-line basis over the life of the asset to the time of the sale.

(3) *Assets acquired by hospitals and SNFs on or after July 18, 1984 and not subject to an enforceable agreement entered into before that date.* Subject to paragraphs (b)(1)(ii) (B) through (G) and (b)(1)(iii) of this section, historical cost may not exceed the lowest of the following:

(i) The allowable acquisition cost 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);

(ii) The acquisition cost to the new owner; or

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

(4) *Assets acquired by all providers on or after December 1, 1997.* Subject to the provisions of paragraph (b)(1)(i)(A) of this section, the historical cost may not exceed the historical cost of the asset, as recognized under the Medicare program, less depreciation allowed, to the owner of record as of August 5, 1997 (or for an asset not in existence as of August 5, 1997, the first owner of record after August 5, 1997).

(5) *Transactions other than bona fide.* If the purchaser cannot demonstrate that the sale was bona fide, in addition to the limitations specified in paragraph (g)(1), (2), and (3) of this section, the purchaser's cost basis may not exceed the seller's cost basis, less accumulated depreciation.

(h) *Sale and leaseback agreements and other lease transactions.* (1) For sale and leaseback agreements for all providers, and for sale and leaseback agreements for hospitals and SNFs entered into before October 23, 1992, a provider may include in its allowable costs incurred rental charges, as specified in a sale and leaseback agreement with a non-related purchaser involving plant facilities or equipment, only if—

(i) 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 agreement;

(ii) Adequate alternate facilities or equipment that would serve the purpose are not or were not available at lower cost; and

(iii) The leasing was based on economic and technical considerations.

(2) If the conditions of paragraph (h)(1) of this section are not met, the amount a provider may include in its allowable costs as rental or lease expense under a sale and leaseback agreement may not exceed the amount that the provider would have included in its allowable costs had the provider retained legal title to the facilities or equipment such as interest expense on mortgages, taxes, depreciation, and insurance costs.

(3) For hospitals and SNFs entering into sale and leaseback agreements on or after October 23, 1992, the amount a provider may include in its allowable costs 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 facilities or equipment, such as interest expense on mortgages, taxes, depreciation, and insurance costs (the costs of ownership). This limitation applies both on an an-

nual basis and over the useful life of the asset.

(i) If in the early years of the lease, the annual rental or lease costs are less than the annual costs of ownership, but in the later years of the lease the annual rental or lease costs are more than the annual costs of ownership, in the years that the annual rental or lease costs are more than the costs of ownership the provider may include in allowable costs annually the actual amount of rental or lease costs. The aggregate rental or lease costs included in allowable costs may not exceed the aggregate costs of ownership that would have been included in allowable costs over the useful life of the asset had the provider retained legal title to the asset.

(ii) If in the early years of the lease, the annual rental or lease costs exceed the annual costs of ownership, but in the later years of the lease the annual rental or lease costs are less than the annual costs of ownership, the provider may carry forward amounts of rental or lease costs that were not included in allowable costs in the early years of the lease due to the costs of ownership limitation, and include these amounts in allowable costs in the years of the lease when the annual rental or lease costs are less than the annual costs of ownership. In any given year the amount of actual annual rental or lease costs plus the amount carried forward to that year may not exceed the amount of the costs of ownership for that year.

(iii) In the aggregate, the amount of rental or lease costs included in allowable costs may not exceed the amount of the costs of ownership that the provider could have included in allowable costs had the provider retained legal title to the asset.

(4) For lease transactions of all providers entered into before October 23, 1992, a lease that meets the following conditions establishes a virtual purchase:

(i) The rental charge exceeds rental charges of comparable facilities or equipment in the area.

(ii) The term of the lease is less than the useful life of the facilities or equipment.

(iii) 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 that 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.

(5)(i) If a lease is a virtual purchase under paragraph (h)(4) of this section, the rental charge is includable in allowable costs only to the extent that it does not exceed the amount that 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 in this paragraph, a provider may not include accelerated depreciation.

(ii) The difference between the amount of rent paid and the amount of rent allowed as rental expense is considered a deferred charge and must be capitalized as part of the historical cost of the asset when the asset is purchased.

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

(iv) 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.

(v) 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.

(6) For lease transactions entered into on or after October 23, 1992, a lease that meets any one of the following conditions establishes a virtual purchase:

(i) The lease transfers title of the facilities or equipment to the lessee during the lease term.

(ii) The lease contains a bargain purchase option.

(iii) 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.

(iv) 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) equals 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.

(7)(i) If a lease is a virtual purchase under paragraph (h)(6) of this section, the rental charge is includable in allowable costs only to the extent that it does not exceed the amount that the provider would have included in allowable costs if it had legal title to the asset (the costs of ownership), such as straight-line depreciation, insurance, and interest. For purposes of computing the limitation on allowable rental cost as described in this paragraph, a provider may not include accelerated depreciation in its allowable costs.

(ii) The difference between the amount of rent paid and the amount of rent allowed as rental expense is considered a deferred charge and is capitalized as part of the historical cost of the asset when the asset is purchased.

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

(iv) 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.

(v) 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.

(vi) If the lessee 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 paragraph (h)(7)(i) of this 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 paragraph (f) of this section.

(i) *Intergovernmental transfer of facilities.* The basis for depreciation of assets transferred under appropriate legal authority from one governmental entity to another is as follows:

(1) The historical cost incurred by the present owner in acquiring the asset under a bona fide sale. The historical cost may not exceed the lower of current reproduction cost adjusted for straight-line depreciation over the life of the asset to the time of the purchase of fair market value at the time of the purchase.

(2) The fair market value at the time of donation under a bona fide donation of the asset (subject to the limitations set forth under paragraph (i) of this section). An asset is considered donated when a governmental entity acquires the asset without assuming the functions for which the transferor used the asset or making any payment for it in the form of cash, property, or services.

(3) If neither paragraph (h) (1) nor (2) of this section applies, for example, 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—

(i) With respect to 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, as permitted under paragraph (d)(2) of this section; or

(ii) With respect to 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 the Medicare program) less depreciation calculated on the straight-line basis over the life of the asset to the time of transfer.

(j) *Basis of assets donated to a provider*—(1) Assets not used or depreciated under the 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 at the time of donation.

(2) *Assets used or depreciated under the Medicare program.* If an asset has 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 lesser of—

(i) The fair market value at the time of donation; or

(ii) The net book value in the hands of the owner last participating in the Medicare program.

(3) *Transfers of State hospitals to non-profit corporations 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 purposes of this section, monetary consideration includes cash, new debt, and assumed debt.

(k) *Transactions involving a provider's capital stock*—(1) *Acquisition of capital stock of a provider.* If the capital stock of a provider is acquired, the provider's assets may not be revalued. For example, if Corporation A purchases the capital stock of Corporation B, the provider, Corporation B continues to be the provider after the purchase and

Corporation A is merely the stockholder. Corporation B's assets may not be revalued.

(2) *Statutory merger.* A statutory merger is a combination of two or more corporations under the corporation laws of the State, with one of the corporations surviving. The surviving corporation acquires the assets and liabilities of the merged corporation(s) by operation of State law. The effect of a statutory merger upon Medicare reimbursement is as follows:

(i) *Statutory merger between unrelated parties.* If the statutory merger is between two or more corporations that are unrelated (as specified in §413.17), the assets of the merged corporation(s) acquired by the surviving corporation may be revalued in accordance with paragraph (g) of this section. If the merged corporation was a provider before the merger, then it is subject to the provisions of paragraphs (d)(3) and (f) of this section concerning recovery of accelerated depreciation and the realization of gains and losses. The basis of the assets owned by the surviving corporation are unaffected by the transaction. An example of this type of transaction is one in which Corporation A, a nonprovider, and Corporation B, the provider, are combined by a statutory merger, with Corporation A being the surviving corporation. In such a case the assets of Corporation B acquired by Corporation A may be revalued in accordance with paragraph (g) of this section.

(ii) *Statutory merger between related parties.* If the statutory merger is between two or more related corporations (as specified in §413.17), no revaluation of assets is permitted for those assets acquired by the surviving corporation. An example of this type of transaction is one in which Corporation A purchase the capital stock of Corporation B, the provider. Immediately after the acquisition of the capital stock of Corporation B, there is a statutory merger of Corporation B and Corporation A, with Corporation A being the surviving corporation. Under these circumstances, at the time of the merger the transaction is one between related parties and is not a basis for revaluation of the provider's assets.

(3) *Consolidation.* A consolidation is the combination of two or more corporations resulting in the creation of a new corporate entity. If at least one of the original corporations is a provider, the effect of a consolidation upon Medicare reimbursement for the provider is as follows:

(i) *Consolidation between unrelated parties.* If the consolidation is between two or more corporations that are unrelated (as specified in §413.17), the assets of the provider corporation(s) may be revalued in accordance with paragraph (g) of this section.

(ii) *Consolidation between related parties.* If the consolidation is between two or more related corporations (as specified in §413.17), no revaluation of provider assets is permitted.

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§413.139 Depreciation: Optional allowance for depreciation based on a percentage of operating costs.

(a) *Principle.* With respect to 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 provider's 1965 operating costs or the provider's current year's allowable costs, whichever are the lower. The percentage 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 regular depreciation on assets acquired after 1965; however, if the optional allowance is selected, the combined amount of such allowance on pre-1966 assets and the straight-line depreciation on assets acquired after 1965 (including the estimated depreciation on assets held on a rental basis during the current year) may not exceed 6 percent of the provider's allowable cost for the current year.

(b) *Definitions*—(1) *Operating costs.* Operating costs are the total costs incurred by the provider in operating the institution or facility.