

(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.

(l) *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—

(i) *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 (l)(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.

(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

schedule are not reimbursable under the program.

[51 FR 34793, Sept. 30, 1986, as amended at 57 FR 33898, 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