PROVIDER REIMBURSEMENT REVIEW BOARD
HEARING DECISION

2001-D34

PROVIDER -
Flowers Hospital Group
Dothan, Alabama

Provider No s.: 01-0055, 01-7013,
01-7020, 01-7048, 01-7072.
26-7262

vs.

INTERMEDIARY -
Blue Cross and Blue Shield Association/
Blue Cross and Blue Shield of Alabama

DATE OF HEARING-
October 18, 2000

Cost Reporting Period Ended -
May 31, 1992

CASE NO. 95-1001G

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ISSUE

1. Was the Intermediary=s adjustment to the Provider=s allowable costs based on the recapture of depreciation proper?

2. Does the Intermediary=s recapture of depreciation due to a gain on the sale of depreciable assets affect the Provider=s calculation of equity capital for prior use?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Issue No 1 - - Recapture of Depreciation

FACTS:

The Flowers Hospital Group (AProviders@) consists of one hospital and four related home health agencies which are located in Dothan, Alabama. The Hospital building was constructed in 1983[1] and was equipped with both new equipment and equipment previously in use at another facility. The home health agencies were acquired in 1987 and their assets included equipment owned by the former owner.[2] The hospital facility, including building, fixed equipment and movable equipment, and the home health assets were sold on May 31, 1992, to an unrelated purchaser.

The Intermediary, Blue Cross and Blue Shield of Alabama, initially determined the Medicare depreciation taken during the period 1983 to 1992 was $24,322,893,[3] but after re-examination, it adjusted depreciation expense to $19,591,136 and reduced the Medicare recapture to $9,110,302.[4] The Providers maintain that no depreciation recapture is due but, in any event, under the law of the Eleventh Circuit in which the Providers are located, the maximum depreciation that is subject to recapture is $12,937,147. The Providers appealed these adjustments to the Provider Reimbursement Review Board (ABoard@). The Providers= filings meet the jurisdictional requirements at 42 C.F.R. '' 405.1835 -.1841. The Providers are represented by Robert A. Klein, Esquire, of Foley and Lardner. The Intermediary is represented by James R. Grimes, Esquire, of Blue Cross and Blue Shield Association.

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1 Transcript (ATr.@) at 37.

2 Id.

3 See Exhibit P-6, 2d pg.

4 See Exhibit 1-10.

PROVIDERS= CONTENTIONS:

As the Providers understand it, the Intermediary asserts that excessive depreciation was taken on the Providers' assets which were subject to recapture to the extent the assets were sold at a gain. For the reasons stated below, not only was no excess depreciation paid to the Providers, but it is virtually impossible under Medicare guidelines for the Providers to excessively depreciate its assets. Accordingly, the basis for the recapture relied on by the Intermediary, i.e., that assets were excessively depreciated, does not exist. The Providers contend that it is the Intermediary=s burden to prove that the depreciation costs paid were excessive. In certain limited situations, the Secretary of Health And Human Services (ASecretary@) is allowed to make retroactive corrective adjustments to costs paid including, presumably, to adjust for excessive depreciation costs paid. 42 U.S.C. ' 1395x(v)(1)(A). That section of the law provides that the Secretary's regulations shall:

> Provide for the making of suitable retroactive corrective adjustments where, for a provider of services for any fiscal period, the aggregate reimbursement produced by the methods of determining costs proves to be either inadequate or excessive.

42 U.S.C. ' 1395x (v)(1)(A)(Emphasis added.)

This section is recognized by the Intermediary as the basis for the Secretary' s regulation to recoup depreciation on the disposal of depreciable assets.[5] Under the statute it is only where an intermediary has Aproved@ that costs reimbursed were Aexcessive@ that a recoupment of such costs is permitted. It is surely not the Providers= burden to establish they were paid excessive costs. In this case no such proof exists. In fact, the record shows a paucity of any Aproof@ presented by the Intermediary. It rested its case without presenting a single witness to attempt to explain its contention that excessive depreciation costs were paid.

The Providers observe that the Intermediary failed to meet its burden to establish that excessive depreciation was claimed by the Providers. During the cost reporting periods in question, FYE 6/30/84 to FYE 5/31/92, the Medicare statute guaranteed that providers would be paid for capital costs based on their actual reasonable costs incurred in providing services to program patients. 42 U.S.C. ' 1395x(v)(1)(A). Since the program began in 1966, depreciation of building and equipment has been recognized by the Secretary as one of the costs incurred in providing care to program patients. 42 C.F.R ' 413.134(a). See, also, 42 C.F.R. ' 413.130. It is undisputed, therefore, that the Secretary is under a duty to recognize depreciation costs actually incurred as a cost of patient care.

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[5] Tr. at 17.

The Providers observe that the Medicare regulations specify the manner in which depreciation is to be computed. The regulations and the Provider Reimbursement Manual track generally accepted accounting principles in calculating depreciation.[6] They require providers to identify the historical cost of the asset and allocate that cost over the asset's useful life on a straight-line basis in accordance with American Hospital Association guidelines. Program regulations originally allowed useful lives to be determined in accordance with guidelines issued by the American Hospital Association or the Internal Revenue Service. However, on August 18, 1983, the regulations were changed to eliminate the application of Internal Revenue Service guidelines as Aobsolete.@[7] A provider has no discretion in computing any aspect of its depreciation costs since it must use actual historical cost, must allocate such cost using the straight-line method of depreciation, and must use the estimated lives of assets that are specified by the program. Thus, 42 C.F.R. ' 413.134(b)(7)(i) applies.

The Providers observe that the underlying issue is not whether the Providers claimed excessive depreciation costs--something they could not do under the Medicare formula--but whether depreciation is measured by allocating historical costs over the asset's estimated useful life or is measured by valuing depreciable assets at the time they are disposed of. The history of the statute and the terms of the regulation and manual indisputably establish that Medicare depreciation is based on an allocation of historical cost rather than on a revaluation of assets at their sale date. It follows that any attempt to recoup depreciation previously paid as "excessive" on the basis of a gain on sale is to measure depreciation on two completely different bases, i.e depreciation is measured for payment purposes on the mechanistic approach described above, but is determined to be excessive for recapture purposes based on asset values at time of sale. Such an approach is without rational basis, and therefore violates law. As the Providers= witness testified, the determination of asset values at time of sale is determined without regard to the Medicare calculation of depreciation.[8]

The Providers further observe that by comparing depreciation costs to gain on sale, the Intermediary improperly used revenue to determine costs. The Medicare statute and regulations mandate that providers be paid their capital-related costs. However, by using a gain on sale as the basis to recoup depreciation costs, the Intermediary has used an illogical and irrelevant basis to measure allowable costs, irrespective of what the regulation appears to require. The gain on sale is the difference between the sales price and the net book value of the assets sold. Under the regulation, the basis for determining the recapture of depreciation is the revenue received from the sale of assets.[9] This revenue is clearly a

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6 Tr. at 70-71.

7 48 Fed. Reg. 37408-11.

8 Tr. at 75-76.

9 Tr. at 78.

non-operating income item, while depreciation is clearly a part of a hospital=s operating expenses.[10] The receipt of revenue resulting in a gain has nothing to do with a provider's operations or the expenses it incurred.[11] Thus, a gain on sale has no conceivable relationship whatsoever to costs which were incurred during the period of 1983 through May, 1992. The two items, revenue and expenses, are simply unrelated to each other. Nothing under generally accepted accounting principles or elsewhere supports a concept that gains from the disposal of assets are netted against costs or expenses incurred. The use of a gain on sale as the basis to recoup depreciation is, simply, a violation of the statutory requirement that a provider be paid its costs.

The Providers further observe that by applying the Arecapture@ regulation to the Providers, Medicare treats providers inconsistently. In this case, Medicare seeks to recoup depreciation on the basis that it was excessively paid. Aside from the contention that no such excessive payment existed, the recapture regulation, if applied here, results in a disparate payment to these Providers when compared to other providers. This is so for at least three reasons. First, certain hospitals that participate in Medicare are leased facilities, often with long-term leases. If the lessee sells its leasehold interest at a Again,@ i.e., any amount above zero, the program makes no attempt to recoup previously paid lease payments.[12] Even though lease payments include a factor for the lessor's depreciation on the leased facility, the regulation does not provide for recoupment of lease payments previously reimbursed the provider. Second, the regulation distinguishes between providers who dispose of assets while participating in the program and those who dispose of assets more than one year following termination from the program.[13] A provider can avoid depreciation recapture simply by leasing its assets for one year with an option in the lease to acquire them after the expiration of the year. See, Hillhaven Corporation v. Schweiker. Secretary of HHS, 570 F. Supp. 248 (M.D. La. 1983). Thus, merely by delaying the disposal of the assets for a one-year period, depreciation recapture is avoided entirely. Third, there is a third class of providers who are not required to pay depreciation recapture. Under 42 C.F.R. ' 413.139, hospitals with assets acquired before 1966 may be paid depreciation under the so-called Aoptional allowance.@ That allowance is based on a percentage of a provider's operating costs incurred in 1965 or in the current year, whichever is lower. HCFA Pub. 15-1 ' 124. When assets subject to the optional allowance for depreciation are disposed of, there is no requirement that depreciation associated with such optional allowance be repaid the program. See HCFA Pub. 15-1' 132.E. Although the use of the optional allowance is merely a different way of recognizing depreciation, the program excludes depreciation recapture when providers elect this method of depreciating assets. See, Christian Hospital of St. Louis v. Califano, No. 76-1167C (E.D. Mo. 1978).

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[10] See AICPA Audit and Accounting Guide, Ex. P-14; Tr. at 79, 84.

[11] Id.

[12] Tr. at 79-80.

[13] Tr. at 81.

The Providers contend that part of the gain realized on the sale of depreciable assets was due solely to inflation and market factors. In Mercy Community Hospital v. Heckler. Secretary of Health and Human Services, 781 F.2d 1552 (11th Cir. 1986), (AMercy Community Hospital@) the court refused to apply 42 C.F.R. ' 413.134(f), formerly section 405.415(f), to allow recoupment of depreciation resulting from the gain on the sale of depreciable assets unless the intermediary could establish that excess depreciation allowances were claimed by the provider. To the extent gains resulted from inflation or market factors, the regulation was deemed inapplicable. The court in Mercy Community Hospital considered 42 C.F.R. ' 405.415(f) as it existed prior to March 20, 1979. Effective that date, the regulation was amended.[14] As the court noted in Mercy Community Hospital, the change in the language of the regulation would not impact its conclusion.

The Providers contend that the evidence in this case[15] shows that the net book value of the Medicare related tangible assets sold was $40,774,973. The Providers= witness, an appraiser for over 50 years, using the Marshall and Swift Index, calculated the reproduction cost-new of the assets sold. His calculations appear on Providers= Exhibits P-28, P-28.1 and P-28.2. They show that the reproduction cost-new of those assets at the time of sale was $45,934,410.[16] The gain due to inflation, therefore, was $5,199,437. The witness also calculated the reproduction cost-new of the assets sold under the Consumer Price Index at $49,204,526, resulting in a larger gain due to inflation, but the Providers have elected to rely on the more conservative calculation. The witness= testimony explaining the reproduction costs in the calculation is in the transcript at 116-124. In addition, this witness testified regarding the impact of market conditions on the sale. The period of 1983 to 1992 was described by the witness as a Aseller=s market@ for hospital sales with numerous buyers available which tended to drive up prices.[17] Hospitals were selling in excess of net book value and net reproduction costs. The witness familiar with the hospital market since at least 1966, stated that hospital prices were increasing faster than inflation during the 10-year period preceding 1992.[18] He estimated that prices increased as a result of market factors at about 1 % per year between 1983 and 1992 and about 10-15% over that period.[19] Based on a sales price slightly in excess of $79,000,000, he stated that about 10% of that number, or $7,900,000, was due to market forces aside from inflation. These two factors, inflation and market,

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14 44 Fed. Reg. 3980 (January 19, 1979).

15 Provider Exhibit P-6, pg. 4; Provider Exhibit P-28.

16 Exhibit P-28.

17 Tr. at 125-126.

18 Tr. at 126-127.

19 Tr. at 127.

account for just under $13,100,000 of the gain. The Agains@ due to inflation and market must be allocated among the assets sold in accordance with Medicare=s rules. Medicare's rules are clear that the gain/loss determination is calculated for each category of assets disposed of, so that the gain or loss for each class can be accurately determined in light of the amount of Medicare depreciation previously allowed for that asset. Thus, gain or loss on sale is separately determined for land improvements, building, fixed equipment, and major moveable equipment.

The Providers observe that the Board recognizes that a gain or loss on sale of depreciable assets must be calculated on the basis of each asset category in St. Luke Hospital v. Aetna Life Insurance Co., PRRB Dec. No. 95-D17, January 12, 1995, Medicare and Medicaid Guide (CCH) & 43,038. In that case the Board found that neither party correctly allocated the total sales price among the assets sold. Instead, the Board found that the appropriate method is to allocate the sales price among the assets sold, land, land improvements, building and equipment. The HCFA Administrator affirmed the Board=s finding that the regulations require the fair market value of each asset sold must be established so that an allocation of the sales price to each such asset can be determined. St. Luke Hospital v. Aetna Life Insurance Co., HCFA Admin. Dec., 95-D17, March 8, 1995, Medicare and Medicaid Guide (CCH) & 43,261. The Board also recognized that a gain or loss on sale must be calculated by category of asset in Peninsula Medical Center v. Blue Cross & Blue Shield Association, PRRB Dec. No. 94-D62, July 29, 1994, Medicare & Medicaid Guide (CCH), & 42,614.

The Providers note that when gain resulting from inflation and market value increases, it is allocated among the assets sold and the Intermediary=s determination of gain is subject to recapture in the amount of $23,548,462[20] is substantially reduced. The allocation of the inflation increase and market factor increase among the assets sold is shown on the attached Schedule I of the Providers= Post Hearing Brief. Under Schedule I the gain due to inflation and the increase in market value is allocated to each major asset category in accordance with their net book value. Because depreciation recapture is limited to actual depreciation taken by asset category, gain due to inflation and market value factors allocated to major movable equipment, in particular, shows a marked reduction in the net depreciation subject to recapture. As a result, the Medicare gain (before adjustments) which the Intermediary found was subject to recapture, $23,548,462, is reduced to $16,894,471.[21] Consistent with Intermediary's Exhibit 1-10, this amount of net depreciation subject to recapture is reduced by salvage value ($245,529), capital reduction amount ($2,058,665), depreciation on assets disposed of ($1,398,618), and home health agency allocated depreciation ($254,512) to a net depreciation expense of $12,937,147 which is subject to the recapture rules.

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[20] Intermediary Exhibit 1-10.

[21] Provider Post Hearing Brief, Schedule I.

The Providers observe that the record in this case has not disputed that any excess of market value or sales price of depreciable assets over the Providers= book value resulted, in part, from an inflationary increase in the market value of the unconsumed remainder of the assets and consisted of investment gains due to supply and demand characteristics of the marketplace or a combination of the two. To the extent that the Intermediary=s application of 42 C.F.R. ' 413. 134(f) refuses to recognize the existence of inflationary and market increases in causing the gains in question, its decision conflicts with the Eleventh Circuit's holding in Mercy Community Hospital. Contrary to the Intermediary=s claims, the holdings under Mercy Community Hospital were not changed by the Deficit Reduction Act of 1984 (ADEFRA@), the statute which became effective on July 18, 1984. The statute is explicit in stating that the rules regarding recapture of depreciation which is accomplished by the determination of gain or loss shall be the same Aas provided under regulations in effect on June 1, 1984,@ i.e., before the statute was adopted. The legislative history of DEFRA confirms that Congress expressly requires the Secretary to continue to recapture depreciation as under current reimbursement policy. There is no basis, therefore, to suggest that DEFRA changed the holding of the Eleventh Circuit on this issue.

INTERMEDIARY=S CONTENTIONS

The Intermediary contends that in 1992 the Providers sold its assets for $99 million. Some $79,025,253 was allocated to patient care assets. The net book value of those assets at the time of sale was $40,774,973, resulting in a gain on sale in the amount of $38,250,280. The Intermediary then recaptured depreciation in the amount of $9,110,302. 42 C.F.R. ' 413.134 permits an allowance for depreciation on buildings and equipment used in the provision of patient care. 42 C.F.R. ' 413.134(f), however, provides that if disposal of a depreciable asset results in a gain or loss, an adjustment is necessary in the provider's allowable cost. 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 methodology for determining the adjustment to allowable costs consists of allocating the gain 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. The results of this allocation are multiplied by the ratio of Medicare reimbursable cost to total allowable cost for each reporting period. The results of this multiplication are then added. Intermediary Exhibit 1-10 sets out the application of the regulatory methodology to the Providers. The allocation of gain to the cost reporting periods under the Medicare program results in a recapture of $9,110,302.00. The Intermediary argues that Medicare regulations require the recapture of depreciation when assets are sold at a gain. Further, the methodology for determining the gain is clear and binding on the parties. The Providers= position in this case, then, clearly violates the regulatory instructions.

The Intermediary contends that the Providers relied instead on the decision in Mercy Community Hospital, addressed supra. In that decision, the court held that the sale of the unconsumed remainder of the depreciable assets at a price in excess of their depreciated book value did not necessarily imply that the provider did not incur some portion of the depreciation cost it was reimbursed for. The court indicated that a gain on sale of depreciable assets may result from other factors, such as market

conditions and inflation. The Intermediary argues that the applicability of 42 C.F.R. ' 413.134(f) has been upheld by the courts and the Provider Reimbursement Review Board on numerous occasions. First, in the case of Professional Medical Care Home. Inc. .v. Harris, 644 F.2d. 589 (7th Cir. 1980) (AProfessional Medical@) the court held
that the Secretary has authority to require providers who leave the program to return allowances for straight line as well as accelerated depreciation in order to avoid allowances for depreciation which turn out not to have been cost actually incurred. The court noted that the provider may argue that receipt of a gain on sale of property may reflect a number of factors such as the fact that inflation may have increased the dollar value, or other circumstances may have caused an increased demand and higher market value for a particular property. Nevertheless, a depreciation formula necessarily produces an inexact estimate of the partial consumption of a physical asset, and it is difficult to be certain that any particular amount is a cost actually incurred. Given these considerations, it is the Intermediary=s conclusion that the regulation, as applied here, is a valid implementation of the statute. The Professional Medical decision was followed in Stewards Foundation v. U.S. 654 F.2d. 28 (Ct. C1.1981); Hoodkroft Convalescent Center Inc. v. State of New Hampshire Division of Human Services, 879 F.2d. 968 (1st Cir. 1989); Hassler Nursing Center v. Sullivan, C.A.No. 89-2770 (D.D.C. 1991). The Board in its decision in St. Mark=s Hospital v. Blue Cross & Blue Shield Association Dec. No. 93-D18, February 19, 1993, Medicare & Medicaid Guide (CCH) & 43,104, affirmed the application of 42 C.F.R. ' 413.134(f) and refused to adjust the application to account for possible effects of inflation. The Board followed the same reasoning in its decision in Lake Medical Center v. Blue Cross and Blue Shield Association, Dec. No. 96-D28, April 16, 1996, Medicare and Medicaid Guide (CCH) & 44,153.

Further, the Intermediary argues that Congress reaffirmed the regulatory requirements of 42 C.F.R. ' 413.134(f) in DEFRA 1984, which required that regulations shall provide for depreciation in the same manner as provided in the regulation in effect on June l, 1984. The regulation in effect on June l, 1984 included subsection f, covering gain on sale of assets.

ISSUE #2 - - ADJUSTMENT TO EQUITY CAPITAL

FACTS:

From 1983 until 1990, the Providers received return on equity ("ROE") payments from the Medicare program.[22] In calculating equity capital for each year, the Providers reduced their equity capital account by the amount of depreciation expense taken, so that equity capital was net of depreciation.[23] When the Intermediary audited the ROE payments for the years in question, it accepted the Providers'

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[22] Tr. at 42.

[23] Id.

calculation of equity capital, i.e., it agreed with the reduction of equity capital by the amount of depreciation expense taken.[24] The Providers request an adjustment to the ROE related to Medicare=s recapture of depreciation due to the sale of assets. The Providers request an increase of approximately $1,210,000[25] in Medicare reimbursement as a result of the gain.

PROVIDERS= CONTENTIONS:

The Providers contend that if they are required to repay depreciation, equity capital must be recalculated. The testimony before the Board shows that the Intermediary failed to increase the Providers= equity capital for prior years to reflect depreciation expense being recaptured. In other words, as depreciation was changed, it reduced current period income which ultimately lowered balance sheet equity. If the depreciation expenses are eliminated, it follows that the equity balance should be adjusted to eliminate the expense that was not incurred. If the Board upholds the determination of depreciation recapture, the Providers' equity capital for the years 1983 to 1990 should be recalculated by adding back depreciation expense that was disallowed and not paid by the Medicare program. The refusal to recalculate equity capital to take into account the disallowance of depreciation expense is inconsistent with Medicare's recalculation of equity capital and ROE in other situations where the amount of depreciation previously claimed by a provider was revised. Medicare recalculated equity capital, and revised ROE payments due to adjustments in depreciation in at least three other situations. First, in cases where there has been a change in the useful life of an asset, equity capital is adjusted to reflect that change. If depreciation expense is increased, equity capital is decreased.[26] Correspondingly, a decrease in depreciation would increase equity capital. Second, when the depreciation schedule for an asset is changed to incorporate a salvage value factor when the original schedule did not reflect salvage value, depreciation is decreased, and equity capital is increased equal to the decrease in depreciation. In such cases, Medicare recalculates equity capital and ROE payments to reflect the application of a salvage factor.[27] Third, when the depreciation methodology is changed from accelerated to straight-line depreciation, Medicare is entitled to recover the excess depreciation paid in certain situations. 42 C.F.R. ' 413.134(d)(3). In such cases, the regulations and the Provider Reimbursement Manual state that if the provider claimed accelerated depreciation and

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[24] Tr.42-43.

[25] See Provider Exhibit P-15.

[26] Tr. at 74-75.

[27] Tr. at 74-78, 91.

changes to straight-line depreciation, recognition will be given to the effects the adjustment to straight-line depreciation would have on the return on equity capital in the respective years. See, also HCFA Pub. 15-1.

' 136.11.[28]

The Providers observe that its witness= testimony further established that in numerous situations when a provider was subject to depreciation recapture, the Medicare program corrected or changed equity capital to reflect the change in depreciation.[29] This was usually allowed by intermediaries, at least prior to 1984. Even after HCFA Pub.15-1 ' 130 was issued in 1984, providers continued to restate equity capital in the event of depreciation recapture.[30] The Providers note that as discussed in the Providers= supplemental position paper and at the hearing, the Board has ruled in numerous previous cases that when depreciation is recaptured, equity capital must be restated.[31] The evidence at the hearing established that the program provided for the revision of equity capital and ROE payments in various situations when a provider's depreciation was adjusted, and that there is no logical reason to allow for the revision of equity capital except in situations when there has been a recapture of depreciation. In addition, the evidence showed that Medicare previously agreed that equity capital should be revised when depreciation is recaptured. In light of the program's shifting position on whether the recapture of depreciation requires a corresponding revision to equity capital, its current position that such revision is not necessary is not entitled to deference.

The Providers observe that at the hearing one of its witnesses testified that he had prepared a schedule of the increased ROE payments to which the Providers are entitled if the Board upholds the full $9,110,302 of depreciation recapture.[32] This schedule adds the depreciation that was recaptured back to the asset bases, and calculates the corresponding ROE payments.[33] The Intermediary did not question either the calculation methodology or the amount of the additional ROE payments. Therefore, the Board is requested to require the Intermediary to revise the Providers= equity capital, and to make additional ROE payments in the amount of $1,210,299.

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28 Tr. at 85-87.

29 Tr. at 87.

30 Tr. at 87-88.

31 Tr. at 88.

32 See Provider Exhibit 24.

33 Tr. at 43-44.

INTERMEDIARY=S CONTENTIONS:

The Intermediary contends that in proposed rulemaking published on October 26, 1987, the Health Care Financing Administration restated its long standing policy that there is no retroactive effect on a proprietary provider=s equity capital for the years prior to the disposition as a result of a gain or loss on the disposal of depreciable assets. This policy was added as Section '130 of the Provider Reimbursement Manual.

The Intermediary argues that the basis of this policy is that a gain or loss does not exist until the year of disposal. Therefore, the gain or loss cannot be taken into account in the computation of equity capital for prior years. Accordingly, any argument by the provider that its equity capital for prior years must be adjusted as a result of the calculation of gain on disposal of assets must be denied. Finally, the Intermediary relies on the decision in Hassler Nursing Center, addressed supra. In that decision, the court reasoned that the Secretary=s reasonable cost determinations and his calculations of Medicare=s payment of return on equity capital have different statutory bases and need not be applied in parallel fashion. The court found the Secretary=s policy of calculating plaintiff=s return on equity capital payments on the basis of the depreciated value of those assets is supported by substantial evidence, is neither arbitrary nor capricious, and is within the boundaries of the Medicare statute.

CITATION OF LAW, REGULATIONS AND PROGRAM INSTRUCTIONS:

1. a.) Law- 42 U.S.C.

'1395x(v)(1)(A)	-	Reasonable Cost
b.) ' 1395x(v)(1)(0)(ii)	-	Deficit Reduction Act of 1984

2. Regulations - 42 C.F.R.:

' 405.415(f) - [redesignated ' 413.134 (f)]	-	Gains And Losses On Disposal Of Assets
'' 405.1835-.1841	-	Board Jurisdiction
' 413.130	-	Introduction To Capital - Related Costs
' 413.134, et seq.	-	Depreciation: Allowance For Depreciation Based On Asset Costs

' 413.139	-	Depreciation: Optional Allowance for Depreciation Based On A Percentage of Operating Costs

3. Program Instructions - Provider Reimbursement Manual, Part I, (HCFA Pub. 15-1):

' 124	-	Optional Allowance For Depreciation Based On A Percentage of Operating Costs
' 130	-	Disposal of Assets
' 132.E	-	Gains and Losses on Disposal of Depreciable Assets (Excluding Involuntary Conversions)
' 136.11	-	Computation of Increase In Equity Capital
Transmittal No. 313	-	Clarification On Disposal of Assets

4. Cases:

Hillhaven Corporation v. Schweiker Secretary of HHS, 570 F. Supp. 248. (M.D. La. 1983).

Christian Hospital of St. Louis v. Califano, No. 76-1167C (E.D. Mo. 1978).

Mercy Community Hospital v. Heckler Secretary of Health and Human Services, 781 F.2d 1552 (11th Cir. 1986).

St. Luke Hospital v. Aetna Life Insurance Company, PRRB Dec. No. 95-D17, Janaury 12, 1995, Medicare and Medicaid Guide (CCH) **&** 43,038.

St. Luke Hospital v. Aetna Life Insurance Company, HCFA Admin. Dec., 95-D17, March 8, 1995 Guide (CCH) **&**43, 261.

Peninsula Medical Center v. Blue Cross & Blue Sheild Association, PRRB Dec. No. 94-D62, July 29, 1994, Medicare & Medicaid Guide (CCH), **&** 42,614.

Professional Medical Care Home Inc. v. Harris, 644 F.2d. 589 (7th Cir. 1980).

Stewards Foundation v. U.S., 654 F.2d. 28 (Ct. C1. 1981).

Hoodkroft Convalescent Center Inc., v. State of New Hampshire Division of Human Services, 879 F.2d. 968 (1st Cir. 1989).

Hassler Nursing Center v. Sullivan, C.A. No. 89-2770 (D.D.C. 1991).

St. Mark=s Hospital v. Blue Cross And Blue Shield Association, Dec. No. 93-D18, February 19, 1993, Medicare & Medicaid Guide (CCH) **&** 43,104.

Lake Medical Center v. Blue Cross and Blue Shield Association, Dec. No. 96-D28, April 16, 1996, Medicare and Medicaid Guide (CCH) 44,153.

Guernsey Memorial Hospital v. Shalala, 115 S. Ct. 1232 (1995).

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

Issue No. 1 - - Recapture of Depeciation

The Board, after considering the facts, parties= contentions, evidence submitted, testimony at the hearing, and post-hearing briefs finds and concludes that since the Providers were located in the United States= Eleventh Circuit, the rationale in the Mercy Community Hospital decision is relevant and applicable to this appeal. Thus, the Providers are entitled to an adjustment to the recapture of depreciation taken. That adjustment, however, is limited to the inflation factor addressed by the Providers.

The Board finds that there was a bona fide sale by the Providers of its facilities to an unrelated party, and that a gain of approximately $23,000,000 resulted. The Intermediary calculated the recapture depreciation taken under the Medicare program at $9.1 million, and the Providers concurred with that amount. The Board further finds that there was no appraisal of assets in the record relating to the sale of the Providers= facilities. 42 C.F.R. ' 413.134(f) - Gains and Losses on Disposal of Assets - applies to the Providers= sale of assets and related recapture of depreciation.

The Board concludes that based on the facts and relevant findings above, a recapture of depreciation is appropriate. The regulatory methodology in 42 C.F.R. ' 413.134 (f) for recapturing depreciation is to determine the gain on the sale, i.e., the difference between the sales price of the assets and the net book value (historical cost less accumulated depreciation taken under the Medicare program). In this case an appropriate gain was calculated and a recapture of depreciation is required.

The Board concludes that in prior cases it has not allowed for adjustments to the depreciation recapture for adjustments such as inflation and relevant market factors. Such adjustments are not addressed by the regulations, and the Board considered them as conceptual hypotheses and inappropriate as they relate to the regulatory requirements of a depreciation recapture. However, since the Providers are in the Eleventh Circuit, the Mercy Community Hospital decision rationale regarding the impact of inflation and market factors applies in the case. Regarding the inflation factor, the Board concludes that the Providers have adequately supported that $5.2 million of the Providers= gain was due to inflation. The Providers= expert witness testimony, as well as Providers Exhibit P-28, reflect the impact of inflation on the sale of assets by the Providers. Regarding market factors affecting an adjustment to the recapture of depreciation, however, the Board finds that the Providers did not provide sufficient evidence to support an adjustment reducing the gain on sale and its resulting reduction in the depreciation recapture. The Providers expert witness= testimony that the prices of facilities increased at a rate of 1% per year between 1983 and 1992[34] was inadequate in and of its self to support this adjustment. Further, there was no appraisal in the record or publications supporting the allegation that markets for hospitals were increasing at 10% annually on average.

The Board concludes that the Mercy Community Hospital decision does not invalidate the Medicare regulation. The decision states that depreciation can be recaptured, as follows:

> [W]here, for example, depreciable allowances paid turn out to have been based on an erroneous estimate of the asset=s useful life or a method of depreciation that does not accurately reflect the actual rate of consumption of the asset over its useful life, the recapture of some portion of those allowances pursuant to regulation 405.415 may be appropriate.

Provider Exhibit P-10 at 1557.

Finally, the allowance for the recapture of depreciation is acceptable under Medicare statute and regulation. In fact the court in Mercy Community Hospital states:

> [W]here the validity of one of the Secretary=s regulations is challenged, the regulation need only be Areasonably related to the purposes of the enabling legislation@ to be sustained. Springdale Convalescent Center v. Matthews, 54 F.2d 943, 951 (5th Cir. 1977) (quoting Mourning v. Family Publications Service, Inc., 411 U.S. 356, 369, 93 S. Ct. 1652, 1660, 36 L.Ed.2d 318 (1973)). The reviewing court is required to grant Aconsiderable deference@ to the agency=s official interpretation of

[34] Tr. at 127.

> statutory terms, Memorial Hospital v. Heckler, 706 F.2d 1130, 1134 (11th Cir. 1983), and a court may not disregard such an implementing regulation Asimply because it would have interpreted the statute in a different manner.@ Batterton v. Francis, 432 U.S. 416, 425, 97 S.Ct. 2399, 2405, 53 L.Ed.2d 448 (1977).

Issue No. 2 - - Adjustment to Equity Capital

The Board finds that the Intermediary=s decision not to recalculate the Providers= Return On Equity (AROE@) was based upon a revision to HCFA Pub. 15-1 ' 130 that was made in 1984. This revision specifically prohibits the revision of ROE to reflect the gain on the sale of a facility as in the instant case by stating a gain or loss on the disposal of depreciable assets has no effect on a proprietary provider=s equity capital for prior years. Moreover, the Board finds that HCFA considered the 1984 amendment to be a clarification of existing policy rather than a new rule as stated in Transmittal 313, the conveying document.

The Board notes the Providers= argument is that the 1984 amendment is invalid, and renders the Intermediary=s refusal improper. In particular, the Providers maintain that the amendment represents a substantive change in program policy. Therefore, to be valid, the amendment would have had to been subject to a notice and comment period in accordance with the Administrative Procedure Act (AAPA@). Contrary to the Providers argument, the Board finds that HCFA=s implementation of the 1984 amendment to HCFA Pub. 15-1 ' 130 without the provision of a notice and comment period does not invalidate its application. The Board finds that the Secretary has already indicated by regulation that there should be recapture of depreciation, and that only reasonable costs shall be reimbursed. The change to the manual instruction in Transmittal No. 313, which clarifies that there will be no retroactive adjustment to ROE, is consistent with these provisions. See, Hassler Nursing Center, supra. The courts have also ruled that HCFA may utilize its manual to establish consistent policies without violation of the APA. See, Guernsey Memorial Hospital v. Shalala, 115 S. Ct. 1232 (1995). Although the manual does not have the effect of law as would a regulation, it is still available to enunciate interpretive rules that are consistent with an existing regulation or statute.

In sum, the Board concludes that HCFA=s 1984 amendment to HCFA Pub. 15-1 ' 130 was a clarification of existing policy which did not violate the APA, and which is a reasonable interpretation of established statutes and regulations. Therefore, the Board finds that the 1984 amendment or clarification is applicable to the subject cost reporting period and is an appropriate basis for the Intermediary=s decision not to reinstate the Provider=s ROE.

DECISION AND ORDER:

Issue No.1-- Recapture of Depreciation

Based on the rationale in the Mercy Community Hospital U.S. Eleventh Circuit court decision, the Providers= are allowed to reduce the recapture of depreciation by $5.2 million due to inflation. The Intermediary=s adjustment is modified.

Issue No. 2 - - Adjustment To Equity Capital

The Intermediary=s refusal to recalculate the Providers= ROE was proper. The Intermediary=s determination was proper.

BOARD MEMBERS PARTICIPATING:

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Henry Wessman, Esq.
Martin W. Hoover, Jr.,Esq
Charles R. Barker
Stanley J. Sokolove

Date of Decision: June 27, 2001

FOR THE BOARD

Irvin W. Kues
Chairman