PROVIDER REIMBURSEMENT REVIEW BOARD
HEARING DECISION

ON THE RECORD
2002-D20

PROVIDER –
Life Care Center of Aurora
Aurora, Colorado

Provider No. 06-5332

vs.

INTERMEDIARY –
BlueCross BlueShield Association/
Riverbend Government Benefits
Administrator

DATE OF HEARING –
March 21, 2002

Cost Reporting Period Ended -
August 31, 1996

CASE NO. 98-2883

INDEX

ISSUE:

Were the Intermediary's adjustments to the Provider's depreciation expense related to the sale and leaseback of the facility proper?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Life Care Center of Aurora ("Provider") is a Medicare certified skilled nursing facility ("SNF") and is located in Aurora, Colorado. The facility is operated by Life Care Centers of America ("LCCA"), which is headquartered in Cleveland, TN. In June of 1993, LCCA purchased the facility from Charter hospital. The purchase price was $3,250,000. Thereafter, significant renovations were conducted in order to convert the facility from a hospital into a SNF. In 1994, building construction and land improvements were performed and major assets were acquired. In order to finance these significant expenditures, Health Realty Trust ("HRT"), a Real Estate Investment Trust ("REIT"), structured the financing in accordance with its normal business practices. (Equity REITs are required to hold a fee simple ownership in order to extend financing. Financing transaction are normally structured to enhance the REIT's debt ratings.) The facility was then sold on August 19, 1994 to HRT for $6,000,000.[1] On the same day, the facility was leased to the Provider.[2] The Provider was certified to participate in the Medicare program in November, 1994.

At the same time that the facility was sold, HRT leased the facility back to Arapahoe Medical Investors Limited Partnership ("Arapahoe"), a related party to LCCA. In turn, Arapahoe entered into an agreement with HRT, whereby it would pay interest on the debt and continue to operate Aurora. At the end of the agreement, a balloon payment would transfer title back to Arapahoe.

The Provider considered the transaction a financing under Generally Accepted Accounting Principles ("GAAP"), and the land, building, and debt were recorded on the Provider's books accordingly. The Provider's Certified Public Accounting firm conducted a cost segregation study to determine the useful life of each fixed asset for purposes of calculating depreciation. The monthly payment of $51,250 was recorded as interest expense. The Provider was also responsible for paying additional amounts each year that was equal to seventy-five percent of the Consumer Price Index ("CPI") increase multiplied by the prior year's payment.

The Provider filed its fiscal year 1996 cost report, recording depreciation and capital related costs for buildings, fixtures, and movable equipment, and the lease payments. Blue Cross Blue Shield

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[1] Intermediary Exhibit I-1.

[2] Intermediary Exhibit I-2.

of Tennessee ("Intermediary") audited the Provider's cost report and determined that the transaction between the Provider and HRT was a sale and leaseback transaction, and therefore only the lease payments paid by the Provider were considered allowable. The Intermediary issued a Notice of Program Reimbursement ("NPR") and audit adjustment report making two adjustments here at issue. First, it adjusted out the stated depreciation expense, citing Provider Reimbursement Manual ("CMS Pub. 15- 1") § 110.A.2 (Medicare sale and leaseback provisions). Second, it adjusted the capital related costs of movable equipment to add in depreciation expense on assets not associated with the financing transaction, citing CMS Pub. 15-1 § 100FF.

The Provider did not agree with the Intermediary's adjustments and properly appealed to the Provider Reimbursement Review Board ("Board") pursuant to 42 C.F.R. §§ 1835-.1841 and has met the jurisdictional requirements of those regulations. The amount of Medicare funds in controversy is approximately $78,000.

The Provider was represented by Thomas C. Fox, Esquire, and Gina M. Cavalier, Esquire, of Reed Smith Shaw & McClay LLP. The Intermediary was represented by Bernard M. Talbert, Esquire, of the Blue Cross and Blue Shield Association.

PROVIDER'S CONTENTIONS:

The Provider argues that the Intermediary is required to follow GAAP when determining Medicare reimbursement for the financing of the facility. An analysis of the substance of the Provider-HRT transaction reveals that the transaction does not meet the Medicare definition of a sale and leaseback, and that it constitutes a financing under GAAP. Since there are no Medicare regulations or instructions addressing this type of transaction and agreement, GAAP must be applied.

The Provider points out that the true essence of the transaction with HRT was to provide the requisite financing to make capital improvements to its physical plant. Although the transaction resembles a sale and leaseback, it is actually a distinct structural arrangement commonly employed by REITs in order to extend financing. The Intermediary has failed to recognize this distinction, despite the fact that federal courts have directed the Centers Medicare and Medicaid Services ("CMS," formerly called the Health Care Financing Adminstration) to review the substance of a transaction, apart from the form, when determining Medicare reimbursement. PIA- Asheville, Inc. v. Bowen, 850 F.2d 739 (D.C. Cir. June 24, 1988) Medicare and Medicaid Guide ("CCH") ¶ 37,162.

The Provider contends that the transaction does not qualify as a sale and leaseback because there was no sale or leaseback. Pursuant to Financial Accounting Standards Board ("FASB") No. 66, in order for a transaction to constitute a sale, the seller cannot have continuing involvement with the property purportedly sold. (FASB No. 66-5). The Provider had significant continuing involvement with the property. It continued to operate the facility as a SNF, maintained and improved the assets, and made interest payments to HRT. Also, the Provider was entitled to make a balloon payment at the end of the agreement in order to reclaim title to the property. Each of these factors demonstrates that the Provider had continuing involvement with the property and,

therefore, the transaction does not constitute a sale under GAAP. Since the precise parameters of sale are not defined in this context under Medicare, GAAP applies.

The Provider argues that in the absence of applicable Medicare regulations or instructions, the Intermediary is required to follow GAAP. CMS has characterized the interplay between Medicare policy and GAAP as a "longstanding position" that GAAP will be followed in situations not covered by Medicare laws and policy. 60 Fed. Reg. 33,126 (June 27, 1995). Also, the Forward to the Provider Reimbursement Manual instructs that for "any cost situation that is not covered by the manual's guidelines and policies, generally accepted accounting principles should be applied." PRM CMS Pub. 15-1 § Forward.

The Provider points out that court decisions have repeatedly affirmed this policy. For example, in Ornda Healthcorp v. Shalala, No. J-C-92-115 (E.D. Ark. Oct. 5, 1993) Medicare and Medicaid Guide (CCH) ¶ 41,975, the court found that no Medicare regulations directly addressed a hospital's particular lease arrangement. The court determined that the hospital's use of GAAP, specifically FASB-13, to report its leasehold costs was proper. Id., (see also HCA Health Servs. Of Midwest, Inc. v. Bowen . 869 F.2d 1179 (9th Cir. 1989). The well settled state of the law leads to the conclusion that the Intermediary must apply GAAP to the transaction. The void in Medicare law and policy provides for no other remedy.

The Provider argues that it is entitled to reimbursement for the cost of ownership under the Social Security Act. SNF's are entitled to reimbursement of their reasonable costs under the Medicare program. The proposed disallowance would deny the Provider reimbursement for a major component of property costs, which is depreciation. Such an expense is a reasonable cost. Therefore, Medicare would not be paying its proportional share of program expenses if this expense were disallowed.

The Provider contends that it only seeks the costs of ownership, including interest and depreciation. The Intermediary mischaracterized the Provider's $51,240 per month expense as lease costs, where such costs were actually interest payments and were recorded on the Provider's general ledger as such.

INTERMEDIARY'S CONTENTIONS

The Intermediary points out that the Medicare regulation at 42 C.F.R. § 413.130 clearly speaks to the cost that can be included in a provider's cost report in relation to a sale and leaseback situation. Subpart (b)(4) of this section states that:

> [f]or sale and leaseback agreements for hospitals and SNFs entered into on or after October 23, 1992, the amount a provider may include in its capital-related costs as rental or lease expense may not exceed the amount that the provider would have included in its capital-related costs had the provider retained legal title to the facilities or equipment, such as interest expense on mortgages, taxes, depreciation, and insurance costs (the cost of ownership). This

limitation applies both on an annual 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 annual costs of ownership, the provider may include in capital-related costs annually the actual amount of rental or lease costs. The aggregate rental or lease costs included in capital-related costs may not exceed the aggregate costs of ownership that would have been included in capital-related costs over the useful life of the asset had the provider retained legal title to the asset.

42 C.F.R. § 413.130(b)(4)(i).

The Intermediary contends that the above section clearly states that "the provider may include in capital-related costs annually the actual amount of rental or lease costs." Id. The Provider, on its as- filed cost report, reported the actual amount of its lease costs and also included the depreciation expense on the leased building, fixtures, and equipment. The Intermediary adjusted the Provider's costs so that the finalized cost report only included the "actual amount of rental or lease costs."

The Intermediary contends that the reporting requirements of a sale and leaseback transaction apply to this case. The Provider clearly transferred the assets to HRT in the transaction of August 19, 1994, and then leased the assets back from HRT on the same date. The Medicare regulation stated above provides guidance to the Intermediary as to the manner in which the related costs should be reported on the Provider's cost report, and the Intermediary has complied with those regulations. The Provider is not entitled to claim depreciation because depreciation is based on the historical costs of the asset as per the regulation at 42 C.F.R § 413.134(a). Since the Provider is the lessee of the assets in question, rather than an owner of the assets, there are no historical costs.

The Intermediary argues that it is not required to adhere to GAAP in making reimbursement decisions. The U.S. Supreme Court's decision in Shalala v. Guernsey Memorial Hospital, 514 U.S. 87 (1995) ("Guernsey"), stated "the Secretary is not required to adhere to GAAP in making provider reimbursement determinations" and "Medicare regulations do not require reimbursement according to GAAP." The Medicare regulations speak clearly concerning sale and leaseback situations.

CITATIONS OF LAW, REGULATIONS AND PROGRAM INSTRUCTIONS:

1. Regulations - 42 C.F.R:

§§ 405.1835 -.1841 - Board Jurisdiction

§ 413.130(b)(4)(i)	-	Leases and Rentals
§ 413.134(a)	-	Depreciation - Allowance for Depreciation Based on Asset Costs

2. Program Instructions - Provider Reimbursement Manual (CMS Pub. 15-1):

Forward

§ 100	-	Depreciation
§ 110.A.2	-	Sale and Leaseback Agreements - Rental Charges

3. Case Law:

PIA - Asheville, Inc v. Bowen, 850 F.2d 739 (D.C. Cir. June 24, 1988), Medicare and Medicaid Guide ("CCH") ¶ 37,162

Ornda Healthcorp v. Shalala, No. J-C-92-115 (E.D. Ark. Oct. 5, 1993) Medicare and Medicaid Guide ("CCH") ¶ 41,975.

HCA Health Servs. of Midwest, Inc. v. Bowen, 869 F.2d 1179 (9th Cir. 1989)

Shalala v. Guernsey Memorial Hospital, 514 U.S. 87 (1995)

4. Other:

Financial Accounting Standards Board of the Financial Accounting Foundation No. 13

Financial Accounting Standards Board of the Financial Accounting Foundation Nos. 66 and 98.

60 Fed. Reg. 33,126 (June 27, 1995).

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board majority, after consideration of the facts, parties' contentions, and evidence presented on the record, finds and concludes that the Provider entered into a sale and leaseback arrangement and is, therefore, not entitled to claim both depreciation and lease payments on its cost report.

The Board majority finds that there was a sale and leaseback which was consummated on August 19, 1994. The Board majority finds that the sales agreement and the lease agreement were both

signed on the same day. In this arrangement the Provider was not the owner of the property in question. Based on the evidence in the file it appears that there was a sale and leaseback, notwithstanding the Provider's contention that in order to a get a loan the Provider was required to sell the property to the Real Estate Investment Trust. The Board majority finds that the monthly payment made by the Provider is actually base rental and not interest. Since it was not the owner of the property, the Provider can not claim the depreciation expense.

The Board majority notes that the Provider did not structure the lease payment to take advantage of the cost of depreciation and other allowable costs. Had the Provider structured the lease payment properly, it could have captured the total cost of ownership. The Board majority notes that perhaps the reason for the lower amount of lease payment was the Provider's cash flow considerations.

In regard to the Provider's argument of the need to utilize Generally Accepted Accounting Principles and the Financial Accounting Standards publication 66 and 98, the Board majority finds that neither is applicable in this situation. The Board majority finds that the decision in Guernsey supra, does not require the use of GAAP.

The Board majority finds that the Intermediary properly added back depreciation on equipment purchased after the sale and leaseback arrangement and properly allowed only the amount of the lease payment.

The Board majority concludes that the Provider is not allowed both depreciation on non-owned assets and the lease payments.

DECISION AND ORDER:

The Intermediary's adjustment disallowing the Provider's depreciation on non-owned assets was proper. The Provider is only entitled to the amount of the lease payments

BOARD MEMBERS PARTICIPATING

Irvin W. Kues
Henry C. Wessman, Esquire
Stanley J. Sokolove
Dr. Gary B. Blodgett
Suzanne Cochran, Esquire (Dissenting Opinion)

Date of Decision: May 16, 2002

FOR THE BOARD

Irvin W. Kues
Chairman

Dissenting Opinion of Board Member Suzanne Cochran

I believe the Medicare regulation at 42 C.F.R.413.130 is as far as we need to look to find that the Provider has not been reimbursed properly under the Intermediary's interpretation. The regulation makes clear that, in a sale leaseback transaction, the lease payment *cannot exceed* ownership costs. The regulation is reasonably designed to prohibit a Provider from artificially inflating its costs, and thus its reimbursement, by transferring ownership but then reacquiring the same asset through a lease.[3] The regulation does nothing more than limit reimbursement to

[3] See 57 F.R. 43906 (Sept. 23, 1992) commentary. The regulation "would limit the amount of lease or rental expense that a hospital or SNF may include in allowable costs under a sale and leaseback transaction . . . to the amount the [Provider] would have included in allowable costs had [it] retained legal title to the asset."

ownership costs to reflect the reality of a sale leaseback.

The Provider presented evidence, uncontroverted by the Intermediary, that the Provider and its independent accounting firm set up the transaction in the Provider's records as if the Provider owned the property.[4] Also uncontroverted was the Provider's evidence that the amount of the lease payment covered nothing but interest - only one component of the ownership costs routinely recognized and reimbursed. There was no evidence presented, nor was there an assertion by the Intermediary, that the interest and depreciation claimed were based on an amount that exceeded the Provider's original cost of the facility in 1993 and its remodeling expense in 1994. The amounts claimed are, therefore, the "amount the [Provider] would have included in allowable costs had [it] retained legal title to the asset." 57 F.R. 43906 (Sept. 23, 1992).

The Intermediary's citation to the regulation that it contends "clearly" limits reimbursement to the lease payment, and, consequently, to interest only, conveniently ignores part of the regulatory language. The Intermediary cites subsection (b)(4) as follows:

> "(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 annual costs of ownership, the Provider may include in capital-related costs annually the actual amount of rental or lease costs. The aggregate rental or lease costs included in capital-related costs may not exceed the aggregate costs of ownership that would have been included in capital-related costs over the useful life of the asset had the Provider retained legal title to the asset."

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[4] The regulation implicitly requires the provider to document ownership costs as if it continued to hold title to demonstrate that its lease payments do not exceed those ownership costs.

The Intermediary then states "This Section clearly states that "the Provider may include in capital-related costs annually **the actual amount of rental or lease costs.**" (Emphasis in Intermediary's statement).[5] The Intermediary fails to even address the qualifying language that links "actual amount of rental or lease costs" to situations in which lease payments will be less than ownership costs in some years and more in others, but, in the end, the total reimbursement is to be equivalent to ownership costs. The uncontroverted evidence in this case is that the lease payment represented interest only and was, therefore, consistently less than ownership costs recognized by Medicare. It is undisputed that a higher lease payment would have been allowed by the Intermediary so long as it did not exceed ownership costs including depreciation as well as interest. The regulation was intended to be a limitation on lease payments that *exceed* ownership costs, not a trap for Providers whose transactions do not precisely fit the circumstances laid out by the regulation.

While the Secretary is not required to use generally accepted accounting principles (GAAP) in making reimbursement determinations, the GAAP cited by Provider support the Medicare regulation in that both recognize the business reality that sale leaseback transactions are a common form of financing and that treatment of the lessee as if it were the owner is proper. The Financial Accounting Standards Board statements offer reasonable guidance for analyzing the proper treatment of the transaction and further illustrate the rationale behind the regulation.

By limiting the Provider's reimbursement to the lease payment, the Provider is deprived of the full ownership costs to which it is clearly entitled under the regulation while the Medicare program receives a windfall, both in violation of the Medicare Act.[6]

Suzanne Cochran April 8, 2002

[5] Intermediary Position Paper, page 5.

[6] 42 U.S.C. 1395x(v)(1)(A) provides in relevant part: " . . . costs of efficiently delivering covered services to individuals covered by [Medicare] will not be borne by individuals not so covered, and the costs with respect to individuals not so covered will not be borne by [Medicare].