REPORT TO THE COMMITTEE ON FINANCE UNITED STATES SENATE

Payments To Hospitals And Extended Care Facilities' For Depreciation Expense Under The Medicare Program'

B-142983

Social Security Administration

Department of Health, Education, and Welfare

BY THE COMPTROLLER GENERAL OF THE UNITED STATES

COMPTROLLER GENERAL OF THE UNITED STATES
WASHINGTON, D.C. 20548

B-142983

Dear Mr. Chairman:

Pursuant to your request of December 10, 1968, this is our report on payments to hospitals and extended care facilities for depreciation expense under the Medicare program.

In accordance with agreements reached with the Committee staff, we considered changes to the regulations dealing with payments for depreciation expense which were proposed by the Department of Health, Education, and Welfare in February 1970 and were subsequently modified in June 1970. The revised regulations were issued in final form by the Department in August 1970.

A draft of this report was made available to the Social Security Administration for its review and comment; however, written comments were not obtained.

As agreed to by the Committee staff, copies of this report are being made available to appropriate officials of the Department of Health, Education, and Welfare. We plan to make no further distribution of this report unless copies are specifically requested, and then we shall make distribution only after your agreement has been obtained or public announcement has been made by you concerning the contents of the report.

Sincerely yours,

Acting Comptroller General
of the United States

The Honorable Russell B. Long
Chairman, Committee on Finance
United States Senate

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ABBREVIATIONS

GAO	General Accounting Office
SSA	Social Security Administration
HEW	Department of Health, Education, and Welfare
ECF	Extended care facility

COMPTROLLER GENERAL'S REPORT
TO THE COMMITTEE ON FINANCE
UNITED STATES SENATE

PAYMENTS TO HOSPITALS AND EXTENDED CARE FACILITIES FOR DEPRECIATION EXPENSE UNDER THE MEDICARE PROGRAM
Social Security Administration
Department of Health, Education, and Welfare B-142983

D I G E S T

WHY THE REVIEW WAS MADE

The Chairman, Committee on Finance, U.S. Senate, asked the General Accounting Office (GAO) to review the methods of reimbursing hospitals and extended care facilities under the Medicare program for depreciation expense--particularly in situations where a facility changes ownership or ceases to participate in the program.

The Medicare program is administered by the Social Security Administration (SSA), Department of Health, Education, and Welfare (HEW). Under SSA reimbursement principles, hospitals and extended care facilities are reimbursed for the reasonable costs, including an allowance for depreciation, of services provided to Medicare beneficiaries.

The original November 1966 SSA regulations provided that the depreciation allowance be computed under the straight-line method with equal amounts being claimed over the estimated useful life of an asset or under an accelerated method, with a larger amount being claimed during the early years of the asset's useful life.

The regulations require that, when a facility used in the Medicare program is disposed of through sale or exchange, any gain or loss realized be used to adjust the allowable costs otherwise due the provider of the service.

In February 1970 SSA proposed certain changes to reimbursement principles dealing with depreciation and the determination of gain or loss. The Committee staff requested that GAO also consider these proposals in its review.

On the basis of the views expressed by the Committee on Ways and Means, House of Representatives, in May 1970, SSA made certain modifications in June 1970 to its changes proposed in February 1970. The revised regulations were made effective in August 1970. The GAO review also considered the latter changes.

FINDINGS AND CONCLUSIONS

Examination into sales of 19 extended care facilities showed that they were being sold at prices substantially exceeding the owners' costs. This situation will result in higher costs under the Medicare program because future depreciation will be based on the higher costs to the new owners. Under SSA's revised regulations, the basis on which depreciation of the facilities will be allowed is limited to the lowest of its (1) cost, (2) fair market value or (3) current reproduction cost less straight-line depreciation. (See pp. 9 through 13.)

Although previous owners of facilities had been paid for accelerated depreciation during their participation in the program, the regulations did not require that, upon termination of their participation, the payments for depreciation be reduced to the amount that would have been paid under the straight-line method. Under SSA's revised regulations, such an adjustment will be required. (See pp. 12 through 15.)

SSA's rationale for initially authorizing accelerated depreciation was (1) to assist providers in the replacement of assets by encouraging the establishment of income-earning funds for such purposes from amounts received through depreciation computed on an accelerated basis, and (2) to facilitate the amortization of providers' debts for assets financed with borrowed capital for periods shorter than ~~their useful lives~~ the life of the asset. (See pp. 15 and 16.)

While SSA did not require that the providers meet the above conditions before ~~being~~ SSA paid for accelerated depreciation, only a small percentage of the providers had actually set aside the amounts received through accelerated depreciation for the purpose of replacing their depreciable assets. Also, SSA had no specific data to show the extent to which providers had actually taken accelerated depreciation to meet their debt payments; however, information compiled by SSA suggested that, on a program-wide basis, the hospitals' needs for accelerated depreciation amounts to meet ~~such~~ their debt payments might not be significant. (See p. 18.)

SSA's revised regulations limit the allowable depreciation to that calculated under the straight-line method for assets acquired after August 1, 1970, except where the provider can demonstrate a need for accelerated depreciation to meet principal payments on debts related to the provider's total depreciable assets. However, the use of accelerated depreciation will still be permitted for certain categories of assets acquired before the effective date of the revised regulations, and the provider will not be required to meet the same criterion for financial need as that applicable to the acquisition of new assets.

GAO was advised that SSA's revised regulations did not provide for uniform application of the criterion for authorizing accelerated depreciation methods to all depreciable assets used in the program because:

1. the primary purpose of the revised regulations is to minimize the increased costs under the program that result from the changes of

ownership of facilities, and the program will not be seriously disadvantaged by the use of accelerated depreciation by providers who remain in the program, and

2. SSA does not want to disturb any of the options available to, and exercised by, providers under the November 1966 regulations. (See pp. 20 and 21.)

Under SSA's November 1966 regulations, gains or losses from the sales or exchanges of depreciable assets were to be considered in determining the amounts of allowable costs reimbursable under the program. A provider could, however, avoid the consideration of a gain by selling the facility soon after he terminated his participation in the Medicare program.

SSA's revised regulations extend the requirement for providers to consider gains or losses realized from assets disposed of to 1 year after the providers' termination of participation in the program. (See pp. 22 through 24.)

RECOMMENDATIONS OR SUGGESTIONS

Because the use of accelerated depreciation by providers is not in line with SSA's reasons for originally authorizing such depreciation methods, GAO believes that there is a possible alternative to the revised regulations. SSA could require that the criterion of financial need as a basis for allowing accelerated depreciation be uniformly applied to all assets regardless of whether they were acquired before or after the effective date of the revised regulations in August 1970. (See p. 21.)

GAO believes also that--because gains or losses on the sale or disposal of depreciable assets can be attributable to factors other than inaccuracies in previous depreciation allowances (such as changes in price levels or general business conditions) and because consideration of gains is limited to the amounts of depreciation which have been charged to the Medicare program--care should be taken by SSA and by the intermediaries to ensure that payments to providers for any losses incurred in the disposal of depreciable assets are also limited to amounts which can be clearly shown to be attributable to inaccuracies in previous depreciation allowances under the program. (See p. 24.)

AGENCY ACTIONS AND UNRESOLVED ISSUES

As pointed out above, HEW's August 1970 revisions to the regulations governing payments to providers for depreciation should, if effectively implemented, result in reducing the costs under the Medicare program. GAO believes, however, that its suggested alternative to the revised regulations discussed above could result in further reductions in program costs.

CHAPTER 1

INTRODUCTION

At the request of the Chairman, Committee on Finance, U.S. Senate, the General Accounting Office examined into the policies, procedures, and practices relating to the reimbursement of depreciation expense to providers of service[1] participating in the Health Insurance for the Aged (Medicare) Program. The Medicare program is administered by the Social Security Administration, Department of Health, Education, and Welfare.

Particular emphasis was placed on situations where ownership of a provider facility changed or where the provider ceased to participate in the program. We evaluated regulations and procedures for recognizing gains or losses on the sales of providers' facilities because, to a certain extent, gains and losses could relate to the amount of depreciation previously charged to the Medicare program. Our review was made at SSA Headquarters in Baltimore, Maryland, and at Blue Cross offices in Oakland and Los Angeles, California. The scope of our review is set forth in more detail in chapter 5 of this report.

DESCRIPTION OF PERTINENT FEATURES OF THE MEDICARE PROGRAM

The Medicare program was established by section 102(a) of the Social Security Amendments of 1965 (42 U.S.C. 1395). This program, which became effective on July 1, 1966, provides two basic forms of protection against the cost of health care for eligible persons aged 65 or over.

One form, designated as Hospital Insurance Benefits for the Aged (part A), covers inpatient hospital services, skilled

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[1] As defined by section 1861(u) of the Social Security Act, approved July 30, 1965 (42 U.S.C. 1395), a provider of services is a hospital, an extended care facility, or a home health agency.

nursing services in extended care facilities, and home health services. This form of protection is financed principally by a special social security tax paid by employees and their employers and by self-employed persons. Amounts received from this tax are deposited into the Federal Hospital Insurance Trust Fund. The assets of the trust fund are invested in interest-bearing certificates of indebtedness of the U.S. Government and in federally-sponsored agency obligations. Providers of service are to be reimbursed from the trust fund on the basis of reasonable costs as determined ~~under~~ from the principles of reimbursement issued by SSA.

The second form of protection is a voluntary program, designated as Supplementary Medical Insurance Benefits for the Aged (part B), and covers physicians' services and other medical and health benefits. Physicians are to be reimbursed on the basis of reasonable charges which may not exceed either the physician's customary charges or the prevailing charges in the locality for similar services. Institutions (providers) furnishing services under part B are to be reimbursed for the reasonable costs of such services.

The hospital insurance portion of the program is generally administered by SSA through private insurance companies nominated by providers to act as fiscal intermediaries on behalf of SSA in making reimbursements to ~~providers~~ them for costs incurred in furnishing services to Medicare beneficiaries. ~~Fiscal intermediaries~~ reimburse providers at least monthly on the basis of estimates of reasonable cost. Adjustments are to be made annually after the ~~intermediaries~~ audit the cost reports submitted by providers ~~and make final cost settlements~~.

Reasonable costs are explained in House Report 213, dated March 29, 1965, by the Committee on Ways and Means, and Senate Report 404, part I, dated June 30, 1965, by the Committee on Finance. These reports state that reasonable costs should approximate actual costs, both direct and indirect, of rendering services to beneficiaries. The reports state further that reasonable costs should include an appropriate amount for depreciation of buildings and equipment but do not specify whether accelerated depreciation ~~should be allowed~~ is allowable in determining reasonable costs.

SSA REGULATIONS AND PROCEDURES GOVERNING THE REIMBURSEMENT TO PROVIDERS FOR DEPRECIATION EXPENSE

In November 1966 SSA issued regulations governing the reimbursement for depreciation expense as part of its principles of reimbursement for provider costs. Although SSA later issued clarifying instructions, the basic regulations remained essentially unchanged. In February 1970, SSA proposed certain important changes to the regulations which relate to the matters discussed in this report. These proposed changes were published in the Federal Register on February 5, 1970, to give interested persons the opportunity to comment on the proposals before their publication in final form.

On the basis of the views of the House Committee on Ways and Means expressed in House Report 91-1096, dated May 14, 1970, SSA made certain modifications in June 1970 to its changes proposed in February 1970.[1] In the following discussion of the November 1966 regulations, we have considered the changes proposed by SSA.

The November 1966 regulations provided that an allowance for depreciation of an asset was to be based on the lower of its (1) cost or (2) fair market value at the time of purchase. Also, fair market value at the date of donation could be used for donated assets. Historical cost is the price paid by the owner in acquiring the asset.

The SSA revised regulations, effective in August 1970, provide that, for any depreciable asset acquired after the effective date, the basis for computing depreciation be the lowest of its (1) historical cost, (2) fair market value, or (3) current reproduction cost less straight-line depreciation.

The November 1966 regulations authorized a provider to compute depreciation of an asset over its useful life,

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[1] The changes to the regulations were published in final form in the Federal Register on August 1, 1970, and were made effective on that date.

using either the straight-line method or one of two accelerated methods of depreciation. Under the straight-line method, the provider may claim depreciation of an asset on the basis of its cost less estimated salvage value in equal amounts over the estimated useful life of the asset. Under methods of accelerated depreciation, the provider may claim depreciation for a larger part of the cost of the asset during the early years of its useful life and relatively smaller parts of the cost during later years.

SSA's revised regulations provide for use of only the straight-line method of depreciation of assets except for those (1) being depreciated on an accelerated method prior to August 1, 1970, (2) acquired before the effective date of the changes for which no option to use either straight-line or accelerated methods had been exercised by the provider, and (3) on which construction had started or on which the provider had made written financial commitments for construction, acquisition, or permanent financing before February 5, 1970 (the date of publication of the proposed changes).

~~Also,~~ for assets acquired after the effective date of the revised regulations, accelerated depreciation--not to exceed 150 percent of the straight-line rate--may be authorized if the provider can demonstrate to the intermediary that ~~the~~ cash received from straight-line depreciation on the provider's total depreciable assets is insufficient to supply the funds needed to meet the amortization of a reasonable amount of principal ~~on~~ debts related to the total depreciable assets.

Under both the ~~November 1966~~ regulations and the revised regulations, the provider may elect to use an optional allowance in lieu of depreciation of assets acquired before January 1, 1966. This optional allowance, which is based on a percentage of other allowable costs (~~less~~ certain exclusions), is in addition to depreciation allowed on assets acquired after January 1, 1966.

Under the ~~November 1966~~ regulations, a provider could change from the straight-line method or optional method of depreciation to an accelerated method with the advance

approval of the intermediary. Under the revised regulations, a provider may not change to an accelerated method for assets previously acquired.

The November 1966 regulations contained no provision for adjusting the amount of accelerated depreciation of a facility previously paid to a provider when the provider terminated his participation in the program prior to sale of the facility. In contrast, the revised regulations require that, if a provider who has used the accelerated method of depreciation terminates or substantially reduces his participation in the program, the amount previously paid to him, under the Medicare program, for depreciation on an accelerated basis be reduced to the amount that would have been paid had the straight-line method been used.

The November 1966 regulations required that, for assets disposed of through sale or exchange, the gain or loss realized on the disposal be considered in determining the amount of allowable costs reimbursable under the program. This requirement is also contained in the revised regulations. The gain or loss on the disposal of an asset is the difference between the sale price and the asset's unrecovered cost (cost less depreciation previously taken).

If an asset is sold at a gain, the total allowable costs otherwise due the provider are to be reduced by the amount of the gain, except that the reduction cannot exceed the amount of payments for depreciation previously paid to the provider under the Medicare program. If the asset is sold at a loss, the allowable costs are to be increased by (1) the full amount of the loss if the asset was acquired while the provider was participating in the Medicare program or (2) a proportionate share of the loss if the asset was acquired before the provider's participation in the program.

The November 1966 regulations did not require the provider to consider the gain or loss on the sale of a facility in determining allowable costs if the facility was sold after the provider terminated his participation in the Medicare program. The revised regulations extend the period during which gain or loss is to be considered to 1 year after termination.

CHAPTER 2

EFFECT OF SALES OF PROVIDER FACILITIES ON THE COSTS OF THE MEDICARE PROGRAM

Our review of a selected number of sales of facilities utilized under the Medicare program indicated to us that such sales had a tendency to increase program costs because of the generally higher sales prices upon which future depreciation payments would be based. SSA officials informed us that certain of the changes in its revised reimbursement regulations were made to limit the increased costs to the program resulting from such sales.

SSA records indicated that a significant number of changes of ownership of provider facilities had occurred throughout the country. The records showed that 497 changes of ownership of extended care facilities (ECFs) occurred between January 1967, when ECFs first became eligible to participate in the Medicare program, and June 1969. These changes represented about 8 percent of the ECF providers who had participated in the Medicare program during the 2-1/2-year period. Also, 196 changes of hospital ownership took place between July 1966 and June 1969, or the equivalent of almost 3 percent of the hospitals which had participated in the program during the 3-year period.

Our examination of changes of ownership was limited to ECFs because the preponderance of such changes pertained to those facilities. Under SSA's terminology, a change of ownership refers to a change of the individual or organization which has been a party to the health insurance benefits agreement with SSA. Therefore, not all changes of ownership necessarily result in sales of the facilities. For example, the original party to the agreement with SSA may retain ownership of the property, but the new party to the agreement with SSA (new provider) may actually operate the facility which he leases from the original party to the agreement.

Of the 497 changes of ECF ownership, about 43 percent, or 214 changes, took place in California. SSA records did

not indicate whether the changes of ownership involved sales of facilities. We visited two intermediaries (Blue Cross plans in northern and southern California) to determine the number of such sales and to obtain information on the gains and losses realized by providers serviced by these intermediaries. SSA records showed that, about the time of our visit, these intermediaries serviced about 585 ECFs, 87 of which had been involved in changes of ownership.

Neither intermediary was able to furnish us with a list of changes of ownership which involved sales of facilities because (1) the providers had not submitted cost reports covering the periods in which the changes of ownership occurred and showing whether facilities were sold and (2) the intermediary had not asked whether a sale had taken place when it became aware of a change of ownership of a provider facility. We were informed by representatives of each of the Blue Cross plans that procedures to identify such sales as soon as possible after learning of changes of ownership would be established.

On the basis of a review of ECF-licensing records at the California Department of Public Health and discussions with Blue Cross officials in California, we identified 22 changes of ownership which involved sales of the facilities. We obtained data on the sellers' costs of the facilities and the sales prices for 19 of the 22 facilities from either the buyers or the sellers. For the remaining three facilities, we could not obtain data on either the costs or the sales prices of the facilities from either the buyers or the sellers.

The following table includes data concerning the 19 facilities. The data pertains to sales of buildings only and does not include sales of equipment or land.

The table shows:

--The sales prices of the facilities, except in one case, exceeded the costs exclusive of accumulated depreciation.

--The average gain on the sale of 13 of the facilities, for which we were able to determine the sellers' book value, was about 73 percent of their book value.

--The method of depreciation used by the sellers and the buyers for Medicare reimbursement purposes for 13 of the 19 facilities.

Examples of Sales of
Extended Care Facilities
Participating in the Medicare Program

Example number	Cost to seller (note a)	Depreciation (note a)	Book value at time of sale	Sales price (note b)	Gain	Gain as percentage of book value	Method of depreciation: Seller	Method of depreciation: Buyer
1	$ 362,000	$ 35,000	$ 327,000	$ 488,000	$ 161,000	49%	Straight-line	Straight-line
2	305,000	58,000	247,000	546,000	299,000	121	Accelerated	Do.
3	884,000	27,000	857,000	1,384,000	527,000	61	Straight-line	Do.
4	660,000	32,000	628,000	895,000	267,000	43	Accelerated	Do.
5	418,000	52,000	366,000	672,000	306,000	84	do.	Do.
6	541,000	60,000	481,000	765,000	284,000	59	do.	Do.
7	443,000	76,000	367,000	615,000	248,000	68	do.	Do.
8	318,000	40,000	278,000	304,000	26,000	9	do.	Do.
9	144,000	50,000	94,000	249,000	155,000	165	do.	Do.
10	103,000	40,000	63,000	222,000	159,000	252	do.	Do.
11	316,000	88,000	228,000	571,000	343,000	150	do.	Do.
12	311,000	48,000	263,000	426,000	163,000	62	Straight-line	Accelerated
13	315,000	101,000	214,000	494,000	280,000	131	Accelerated	Do.
	5,120,000	$707,000	$4,413,000	7,631,000	$3,218,000	73[c]		
14	328,000	(d)		330,000	$ 2,000[d]			
15	229,000	(d)		370,000	141,000[d]			
16	219,000	(d)		295,000	76,000[d]			
17	292,000	(d)		650,000	358,000[d]			
18	286,000	(d)		659,000	373,000[d]			
19	123,000	(d)		221,000	98,000[d]			
	1,477,000			2,525,000	$1,048,000			
	$6,597,000			$10,156,000				

[a]Cost and depreciation data obtained from seller or from seller's cost reports. The amount of depreciation shown represents the total amount charged by the provider after acquisition of the property, including periods prior to his participation in the Medicare program.

[b]All sales prices shown were obtained from buyers; however, in two cases, the sellers supplied us with selling prices which differed from those shown. The reason for the differences was that the facilities, equipment, and land were sold at lump-sum prices and there were variations in the values placed on the facilities by the parties to the sales. For the purpose of determining future depreciation charges under the Medicare program, the sales prices shown are subject to approval by the intermediaries.

[c]Average gain.

[d]The amount of gain shown is understated by the amount of depreciation since the acquisition of the facility. We were unable to determine the amount of depreciation because the provider had not filed with the intermediary cost reports showing such data.

AGENCY ACTIONS

Under the SSA November 1966 regulations, the foregoing sales will result in higher costs under the Medicare program because future depreciation of the facilities will be based on the higher costs to the new owners (amounts shown in the sales column of the preceding table) if the intermediaries consider such amounts not to be in excess of fair market values.

We were informed by SSA officials that the revised regulations, which add current reproduction cost less straight-line depreciation at the time of purchase as a criterion for limiting the basis for computing future depreciation, were established in recognition of higher program costs that resulted from sales of facilities where prices paid for the facilities by the new providers substantially exceeded the selling providers' costs.

The November 1966 regulations did not require that payments for depreciation of facilities on an accelerated basis to providers, which had terminated their participation in the program prior to the sale of the facilities, be reduced to the amounts that would have been paid under the straight-line method although the terminated providers had subsequently realized substantial gains on the sales.

Adjustments of prior allowances to a provider for accelerated depreciation are now required under SSA's revised regulations whenever the provider terminates or substantially reduces his participation in the program. According to SSA, this provision was developed in recognition of the fact that the program could be seriously disadvantaged through higher program costs when an asset changes hands after depreciation has been allowed on an accelerated basis, particularly where the new provider also elects to take accelerated depreciation on the same asset.

In our opinion, the actions taken by SSA to adjust amounts previously allowed for accelerated depreciation whenever providers leave the program should, if effectively implemented, result in reducing the costs for depreciation under the Medicare program. Also, the action taken to

further limit the basis for depreciation charges in instances where facilities are sold to new providers should result in reduced costs if the current reproduction costs, as adjusted by straight-line depreciation, are less than either the historical cost or the fair market value of the facilities.

CHAPTER 3

CHANGES IN METHOD OF DETERMINING AMOUNTS OF DEPRECIATION EXPENSE PAYABLE TO PROVIDERS OF SERVICE

The changes in the SSA regulations governing the reimbursement for depreciation expense are in line with some thoughts we expressed on accelerated depreciation in our May 1966 report to the Committee.[1]

Generally, for assets acquired after the effective date of the revised regulations, the amount allowable to a provider for depreciation would be limited to that calculated under the straight-line method except where the provider could demonstrate a need for accelerated depreciation to meet payments on the principal for debts related to the provider's total depreciable assets. Also, after the effective date of the revised regulations, a provider could no longer change from the straight-line or optional methods of depreciation to an accelerated method. In our May 1966 report, we pointed out that we considered it inappropriate to permit the initiation of accelerated depreciation methods for used assets previously depreciated on the basis of the straight-line method.

In addition, SSA's revised regulations require that, if a provider using accelerated depreciation terminates or substantially reduces its participation in the Medicare program, the amount paid for depreciation under the program be reduced to the amount that would have been paid had the straight-line method been used. This change is consistent with the views set forth in our May 1966 report wherein we stated that--unless provision was made to require some adjustments to past payments for depreciation of facilities

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[1] Report to the Committee on Finance, U.S. Senate, by the Comptroller General of the United States entitled "Review of Proposed Principles of Reimbursement for Provider Costs under Public Law 89-97" (B-142983, dated May 24, 1966).

in appropriate circumstances, such as where the facility was suitable for, and would continue in use as, a medical facility and where an accelerated method of depreciation had been used by the transferring provider--abuses to the program through the sales of facilities for the primary purpose of realizing gains would be invited.

The revised regulations, however, would still permit the use of accelerated methods of depreciation for (1) assets being depreciated on that basis as of the effective date of the revised regulations, (2) assets acquired before the effective date of the revised regulations for which no option to use either straight-line or accelerated methods had been exercised by the provider, and (3) assets on which construction was started or on which the provider had made commitments for construction, acquisition, or permanent financing before February 5, 1970. Accelerated depreciation would continue to be authorized for these three categories of assets without regard to whether the provider could meet the condition relating to financial need which must be met by providers taking accelerated depreciation on assets acquired after the effective date of the revised regulations.

BASES FOR SSA ORIGINALLY ALLOWING ACCELERATED DEPRECIATION

The reasons for originally allowing payments to be made to providers for accelerated depreciation were discussed by the Commissioner of Social Security in a presentation of the proposed Medicare principles of reimbursement to the Committee on Finance in May 1966. The Commissioner stated that the principles allowed an institution to follow generally approved accounting methods for taking accelerated depreciation as well as straight-line depreciation. He stated also that it would often be necessary to accelerate the depreciation of assets financed with borrowed capital to provide payments for depreciation sufficient to meet the providers' debt payments when the purchase of the assets was financed for periods shorter than their useful lives.

Regarding the depreciation of an asset financed with capital that was not borrowed, the Commissioner pointed out that accelerated depreciation helped to meet the greater

cost of replacing the asset as compared with the original cost. The foregoing objective could be accomplished by establishing a fund equal to the amount of depreciation charged which, in turn, would earn interest. Because, under accelerated depreciation, a larger part of the cost of an asset is paid to the provider during the earlier years of its useful life, the interest accrued over the useful life of the asset would be greater than the interest which would accrue by charging straight-line depreciation.[1] In this connection, the principles of reimbursement provide that, if a provider establishes a fund for the replacement of assets, any income earned on such a fund not be considered as a reduction of the provider's allowable costs, as is the case for certain other income earned by the provider.

In summary, SSA's reasons for initially authorizing accelerated depreciation were (1) to assist providers in the replacement of assets by encouraging the establishment of income-earning funds for such purpose from amounts received through depreciation computed on an accelerated basis and (2) to facilitate the amortization of providers' debts for assets financed with borrowed capital for periods shorter than their useful lives.

Although these were the reasons for allowing accelerated depreciation, providers were not required to meet such conditions in order to use accelerated depreciation methods under the November 1966 regulations; i.e., the option to use either straight-line or accelerated methods of depreciation was left to the discretion of the providers.

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[1] To illustrate this point--if depreciation charges on a straight-line basis, applicable to an asset with a useful life of 20 years, were accumulated in a fund earning 4-percent interest, the fund would amount to about 150 percent of the original cost of the asset at the end of the 20 years. ~~However,~~ Whereas, if depreciation were charged on an accelerated method (sum-of-the-years' digits), the fund, including interest, would amount to about 180 percent of the original cost of the asset at the end of 20 years.

In contrast, under SSA's revised regulations, if a provider wishes to take accelerated depreciation--not to exceed 150 percent of the straight-line rate--for assets acquired after the effective date of the revised regulations, the provider must demonstrate to the satisfaction of the intermediary that accelerated depreciation payments are needed to meet the amortization of a reasonable amount of principal on debts related to the provider's total depreciable assets.

PRACTICES OF PROVIDERS RELATING TO ACCELERATED DEPRECIATION

Regarding the first reason, as stated above, for originally authorizing accelerated depreciation, we found that only a small percentage of the providers actually funded the amounts received through depreciation for the purpose of replacing their depreciable assets.

The following table shows the depreciation methods used for Medicare reimbursement purposes by a sample of 155 hospitals and 134 ECFs located in the 50 States, Puerto Rico, the Virgin Islands, and the District of Columbia. The data pertaining to these providers were obtained from files of unaudited cost reports at SSA Headquarters in Baltimore, Maryland.

Method of depreciation	Hospitals		Extended care facilities	
	Total	Funding depreciation	Total	Funding depreciation
Straight-line	91	22	49	4
Accelerated	7	1	38	2
Optional (note a)	40	6	5	1
Not determined (note b)	17	1	42	1
Total	155	30	134	8

[a] An allowance in lieu of depreciation which is calculated as a percentage of other allowable costs less certain exclusions. (See p. 7.)

[b] Cost reports did not clearly show the method of depreciation used by the provider.

As shown in the above table, only 30 (about 19 percent) of the hospitals and eight (about 6 percent) of the ECFs funded the amounts allowed for depreciation. In regard to those providers who claimed depreciation on an accelerated basis, only one of seven hospitals and two of 38 ECFs funded the depreciation allowances.

This data indicates to us that in practice providers claiming accelerated depreciation are not establishing special funds to meet the greater costs of replacing depreciable assets.

Concerning the use of accelerated depreciation to facilitate the amortization of providers' debts applicable to assets financed with borrowed capital, we noted that, under the November 1966 Medicare reimbursement principles, accelerated depreciation could be taken at the option of the providers without giving any regard to whether the higher depreciation allowances were needed to make debt payments. Furthermore, we were informed by SSA that it had no specific data to show the extent to which providers had taken accelerated depreciation for this purpose.

In the absence of such specific data, we obtained information compiled by SSA from more than 1,000 hospital cost reports pertaining to the first year of the Medicare program. This information showed that, on an overall basis, the hospitals' long-term debts applicable to depreciable assets represented about 8 percent of the costs of the assets. We estimate that, under the accelerated depreciation methods originally authorized by SSA, this debt is equivalent to about the first 2 years of accelerated depreciation for assets with useful lives of 40 years. This suggests to us that, on a program-wide basis, the need for hospitals to be paid for accelerated depreciation to meet payments on the principal of such long-term debts may not be significant.

We compiled and analyzed similar information for 172 ECFs for cost-reporting periods that ended during calendar year 1968. This information showed that the amount of the ECFs' long-term debt was about 46 percent of the cost of their depreciable assets. Our analysis, as summarized in the following table, showed that some ECFs with relatively small indebtedness in relation to the costs of depreciable assets were taking accelerated depreciation whereas other ECFs with relatively large indebtedness in relation to the costs of depreciable assets were taking straight-line depreciation.

Percent of long-term debt to costs of depreciable assets	Method of depreciation used (number of ECFs)					
	Total	Straight-line	Straight-line and accelerated (note a)	Accelerated	Optional	Not shown
0 to 10	49	21	6	5	9	8
11 to 25	9	3	1	3	-	2
26 to 50	21	8	3	5	2	3
51 to 75	37	14	3	17	-	3
Over 75	56	16	4	28	2	6
Total	172	62	17	58	13	22

[a]This indicates that the ECF was taking straight-line depreciation on some assets and accelerated depreciation on other assets.

GAO COMMENTS ON CONTINUING ACCELERATED DEPRECIATION ALLOWANCES

We agree with the provision in SSA's revised regulations which would limit the depreciation allowable to a provider to that calculated under the straight-line method for assets acquired after the effective date of the revised regulations except where the provider can demonstrate a need for accelerated depreciation to meet payments on the principal of debts related to the provider's total depreciable assets.

We noted that the revised regulations provide that accelerated depreciation would be allowed for certain categories of assets acquired before the effective date of the revised regulations without requiring the providers to meet the same criterion for financial need as applicable to the acquisition of new assets. Increased program costs will arise because the use of accelerated depreciation methods results in (1) larger cash payments during the early years of the life of an asset than payments on a straight-line basis and (2) smaller cash payments during the later years of the life of an asset than payments on a straight-line basis. These larger cash payments during the earlier years result

in a net loss of interest income over the life of the asset which would have accrued to the Medicare program if the additional funds required to pay the accelerated depreciation allowances had remained on deposit in the Federal Hospital Insurance Trust Fund.

We were advised by an SSA official that SSA's revised regulations do not provide for uniform application of the criterion for authorizing accelerated depreciation methods to all depreciable assets used in the program because (1) the primary purpose of the revised regulations is to minimize the increased costs under the program that result from the changes of ownership of facilities and the program would not be seriously disadvantaged by the use of accelerated depreciation by providers who remain in the program and (2) SSA does not want to disturb any of the options available to, and exercised by, providers under the November 1966 regulations.

As pointed out previously in this chapter, however, we found that the use of accelerated depreciation by providers is not in line with SSA's reasons for originally authorizing such depreciation methods. For example, our review indicated that, generally, the need for hospitals to be paid for accelerated depreciation of depreciable assets acquired before the effective date of the revised regulations may not be significant.

Accordingly, we believe that a possible alternative to the revised regulations would be for SSA to make the continued use of accelerated depreciation methods dependent upon the providers meeting the same criterion for financial need with regard to assets acquired before the revised regulations that are to be met by providers taking accelerated depreciation for assets acquired after the effective date of the revised regulations.

CHAPTER 4

CHANGES IN REIMBURSEMENT PRINCIPLES RELATING TO GAINS AND LOSSES ON DISPOSAL OF DEPRECIABLE ASSETS

The SSA revised regulations expand the conditions under which gains or losses on sales of depreciable assets are to be considered in determining allowable costs.

Under the SSA November 1966 principles of reimbursement, gains or losses from the sales or exchanges of depreciable assets were to be considered in determining the amounts of allowable costs reimbursable under the program. Under these 1966 regulations, however, a provider could avoid the consideration of a gain by selling a facility soon after it terminated its participation in the Medicare program.

One of the cases involving a sale of a facility, which we examined into during our review, illustrates this point. The provider, listed as number 13 in the table on page 11, began participating in the Medicare program on January 1, 1967. On September 23, 1968, the provider voluntarily terminated its agreement, and the facility was sold on October 31, 1968. During its participation in the program, the provider's depreciation charges, on an accelerated method, for the facility were about $24,800, of which about $4,200 was charged to the Medicare program.

The selling price of the land, building, and equipment was $740,000. According to the provider's cost reports, the book value of the land, building, and equipment was about $271,000. The seller informed us that the allocation of the cost and selling price for the land, building, and equipment, which would result in a loss of $17,000 on the building and equipment, was as follows:

	Cost	Book value	Sales price	Gain or loss(-)
Land	$ 35,000	$ 35,000	$521,000	$486,000
Building	315,000	214,000)	219,000	-17,000
Equipment	79,000	22,000)		
	$429,000	$271,000	$740,000	$469,000

The buyer entered into a provider agreement with SSA on September 23, 1968. The buyer's allocation of the $740,000 price to land, building, and equipment was substantially different from the seller's allocation. The allocation, as shown by the buyer, and the indicated gain on the building and equipment were as follows:

	Book value	Sales price	Gain
Land	$ 35,000	$120,000	$ 85,000
Building	214,000	494,000	280,000
Equipment	22,000	126,000	104,000
	$271,000	$740,000	$469,000

In considering the gain or loss, however, the final decision as to the value of the facility for purposes of determining allowable costs had not been made by the intermediary at the time of our review. If the intermediary decides that the selling provider did, in fact, profit on the sale of the facility, he may not, under SSA November 1966 regulations, be required to recognize any of the gain up to the amount of depreciation previously charged to the Medicare program (about $4,200) because he had terminated his provider agreement with SSA before the sale.

SSA CHANGES TO THE PRINCIPLES OF REIMBURSEMENT

Under SSA's revised regulations, providers are required to consider in determining allowable costs gains or losses realized from assets disposed of within 1 year after the providers' termination of participation in the program.

Gains or losses on the sale or disposal of depreciable assets can be attributable to factors other than inaccuracies in previous depreciation allowances, such as changes in price levels or general business conditions in the health care field. Further, as stated on page 8, the consideration of any gains is limited to the amounts of depreciation previously charged to the Medicare program. Therefore, we believe that, in administering the revised regulations, care should be taken by SSA and by the intermediaries to ensure that payments to providers for any losses incurred in the disposal of depreciable assets, either before or after providers' terminations from the program, are also limited to amounts which can be clearly shown to be attributable to inaccuracies in previous depreciation allowances under the program.

CHAPTER 5

SCOPE OF REVIEW

We examined SSA's regulations issued in November 1966 and related instructions pertaining to methods of depreciation that providers may use for reimbursement purposes under the Medicare program. We also reviewed and evaluated SSA's proposed changes to the regulations, published in the Federal Register in February 1970 and issued in final form in August 1970, pertaining to depreciation allowances. We evaluated SSA's regulations and procedures for recognizing gains or losses upon the sales or other disposition of providers' facilities because the recognition of gains or losses, to a certain extent, could relate to the amounts of depreciation previously charged to the Medicare program by the providers.

Our examination included a review of supporting documentation for SSA determinations of the methods of depreciation which would be allowed and a review of the legislative background pertinent to the consideration of depreciation allowances.

We examined into changes of ownership of ECFs in the State of California to ascertain the extent of gains on the sales of facilities and the effectiveness of the November 1966 regulations in providing for recognition of such gains in determining allowable costs for Medicare program reimbursement purposes.

Our review was made at SSA Headquarters in Baltimore, Maryland, and at two SSA intermediaries in California--Blue Cross offices located in Oakland, California, and in Los Angeles, California. We also examined license files for ECFs at the California Department of Public Health in Los Angeles, California, to obtain information concerning changes of ownership.

U.S. GAO, Wash., D.C.