

The plaintiff, Mercy Hospital, seeks judicial review of a decision of the Secretary of Health and Human Services made pursuant to the Medicare program, Title XVIII of the Social Security Act, 42 U.S.C. ' ' 1395 - 1395ccc (``Title XVIII"). The Secretary found that the plaintiff was not entitled to claim full reimbursement of certain losses in a single cost year and must instead amortize the losses over approximately fourteen future cost years. The case comes before the court on cross-motions for judgment on a stipulated record.² Jurisdiction in this court vests under 42 U.S.C. ' 1395oo(f)(1). For the reasons enumerated below, I grant the plaintiff's motion for judgment.

I. FACTS AND REGULATORY SCHEME

The relevant facts may be summarized as follows. The plaintiff, Mercy Hospital (``Hospital"), is a non-profit acute-care facility located in Portland, Maine. Stipulation of Facts & 2. The Hospital is an approved provider of hospital services under the Medicare program. *Id.* Defendant Louis W. Sullivan is the Secretary of the United States Department of Health and Human Services (``HHS"). *Id.* & 3. In that capacity, he is responsible for administering the Medicare program and for reviewing Medicare reimbursement decisions issued by the Provider Reimbursement Review Board (``PRRB"). *Id.*

A. The Medicare Program - General Provisions

The Medicare program, established by Title XVIII, is a national program of health insurance for eligible disabled and elderly citizens. *Id.* & 4. Hospitals and other medical providers who qualify

² This procedural device allows a court to resolve any lingering issues of material fact in reaching its decision on the merits. *Boston Five Cents Sav. Bank v. Secretary of the Dep't of Hous. & Urban Dev.*, 768 F.2d 5, 11-12 (1st Cir. 1985).

under the Medicare program are reimbursed for the services they provide to Medicare beneficiaries. *Id.* Such providers are entitled to be reimbursed for reasonable costs incurred in providing covered services to Medicare recipients. *Id.* & 5; *see, e.g.*, 42 U.S.C. ' 1395f(b). ``Reasonable costs" are the costs ``actually incurred, excluding therefrom any part of incurred cost found to be unnecessary in the efficient delivery of needed health services . . ." 42 U.S.C. ' 1395x(v)(1)(A); Stipulation of Facts & 5. Title XVIII requires the Secretary to promulgate regulations that interpret ``reasonable costs" pursuant to ``principles generally applied by national organizations." 42 U.S.C. ' 1395x(v)(1)(A); Stipulation of Facts & 5.

A provider of services receives its Medicare payments through a ``fiscal intermediary" that acts as an agent of the Secretary for the purpose of reviewing the provider's claim for reimbursement. 42 U.S.C. ' 1395h; Stipulation of Facts & 8. The fiscal intermediary determines the final amount of payment due the provider for the fiscal year. *Id.* The Blue Cross Association, acting through its subcontractor, Blue Cross and Blue Shield of Maine (``Intermediary"), was the Hospital's intermediary at all times relevant to this action. Stipulation of Facts & 8.

In order to be reimbursed for its reasonable costs of providing services to Medicare beneficiaries, a provider must file a cost report with its intermediary. 42 C.F.R. ' 413.24(f); Stipulation of Facts & 9. The intermediary audits the provider's cost report and issues a Notice of Program Reimbursement (``NPR") informing the provider of the amount it will be reimbursed. 42 C.F.R. ' 405.1803; Stipulation of Facts & 10.

If the provider disputes the amount of the reimbursement due under its NPR, and the dispute involves at least \$10,000, the provider may request a hearing before the PRRB to review the matter. 42 C.F.R. ' 405.1835; Stipulation of Facts & 11. The Secretary, acting through the Health Care Financing Administrator (``HCFA"), may affirm, reverse or modify the PRRB's decision. 42 C.F.R. ' 405.1875; Stipulation of Facts & 11. The provider, if dissatisfied with either the PRRB's decision or

the Secretary's action thereon, may bring a civil action for judicial review in federal district court. 42 U.S.C. ' 1395oo(f)(1); Stipulation of Facts & 12.

B. Overview

The Secretary has promulgated regulations governing Medicare payment to providers at 42 C.F.R. ' ' 413.1 - 413.179. Stipulation of Facts & 6. The regulations state as a general principle that payments to providers `` must be based on the reasonable cost of services covered under Medicare and related to the care of beneficiaries." 42 C.F.R. ' 413.9; Stipulation of Facts & 6. Costs that are reimbursible include not only medical costs but also expenses of maintaining facilities to the extent that such expenses are allocable to Medicare beneficiaries. *See* 42 C.F.R. ' 413.9(b)(1), (b)(2); Stipulation of Facts & 6.

The Hospital in the instant case challenges the Secretary's treatment of just such an ``indirect" cost of doing business. Specifically, the Hospital disputes the timing of the Secretary's reimbursement of the Medicare portion of costs incurred in fiscal year 1984 to refinance debt issued to upgrade its facilities. The Hospital and the Secretary do not dispute that the amount claimed is reasonable, in the sense that it covers the portion of costs reasonably attributable to Medicare beneficiaries. *See* Defendant's Memorandum in Support of Motion for Summary Judgment and in Opposition to Plaintiff's Motion for Summary Judgment (``Defendant's Memorandum") at 2 and Plaintiff's Memorandum of Law (``Plaintiff's Memorandum") at 3. They dispute only the timing of reimbursement. The Secretary contends he may permissibly amortize the reimbursement over fourteen years; the Hospital asserts that the Secretary's own regulations dictate full reimbursement in the year incurred.

C. Facts Specific to Present Lawsuit

In 1982 the Hospital obtained a Maine Certificate of Need and HHS approval to obtain funds to renovate and upgrade its facilities. Stipulation of Facts & 28. The Hospital applied to the Maine Health and Higher Education Facilities Authority ("Authority") for a bond series through which funds could be obtained to finance the project. *Id.* On February 15, 1982 the Authority issued \$16,300,000 worth of revenue bonds, designated as Mercy Hospital Issue "Series A" bonds, which paid an approximate interest rate of 14 percent to bondholders. *Id.* As interest rates began to fall late in 1982, the Hospital considered an "advance refunding"³ of its Series A bonds in order to take advantage of the lower interest rates. *Id.* & 29. The Hospital's Board of Trustees authorized the advance refunding in June 1983. *Id.*

In fiscal year 1984 the Hospital undertook the advance refunding its trustees had authorized. *Id.* & 14. The Hospital, again through the Authority, issued \$20,325,000 worth of "Series B" bonds bearing an interest rate of approximately 10 percent. *Id.* & 30. The Hospital placed approximately \$19,800,000 of the Series B proceeds into an irrevocable escrow fund with the Maine National Bank as designated Trustee. *Id.* The Trustee has invested the fund in certain United States Treasury obligations at rates that will be sufficient to pay the principal of and interest on all Series A bonds on July 1, 1992, the first call date for that issue. *Id.*

³ An advance refunding transaction occurs when an institutional borrower retires its outstanding bonds with a new series of bonds at a lower interest rate. Even though an advance refunding produces lower interest rates that ultimately benefit the borrower, the borrower does incur up-front losses on the transaction. Such losses may make it difficult for the borrower to obtain additional financing or capital because it weakens the borrower's debt-to-equity ratio. *See* Stipulation of Facts && 14-15, 18.

The advance refunding was projected to result ultimately in a savings of approximately \$6,300,000 in interest expense. *Id.* & 31. To accomplish this, however, the Hospital was forced to incur a one-time debt cancellation loss of \$3,960,878. *Id.* This loss was a result of the increased principal amount needed to defease the Series A bonds and to meet other costs associated with the Series B transaction. *Id.* Therefore, the final savings that would accrue to the Hospital as a result of the advance refunding was approximately \$2,300,000. *Id.*

The Hospital claimed only part of its advance refunding loss as a cost to be reimbursed in its 1984 Medicare cost report, even though the loss was reflected in its entirety as an extraordinary loss in the Hospital's audited financial statements for that year. *Id.* & 32. The Hospital claimed only part of its loss because of its reading of Sections 215 and 215.1 of the Secretary's Provider Reimbursement Manual ("PRM"). *Id.*

The PRM provides intermediaries with guidance on how to implement Medicare regulations. *Id.* & 24. It does not have the binding effect of a law or regulation because it is not promulgated in accordance with the rulemaking provisions of the Administrative Procedures Act. *Id.* Sections 215 and 215.1 of the PRM, in effect during the cost period at issue here and now obsolete, dealt with the subject of "costs incident to the recall of bonds."⁴ *Id.* & 25. These sections provided that such costs be amortized over future periods. *Id.* Section 215 stated, in part:

Costs incident to the recall of bonds before their date of maturity are considered debt cancellation costs and are allowable to the extent they are reasonable.

Id. Section 215.1 stated, in part:

⁴ In May 1983, the Secretary published a new manual provision, Section 233, specifically dealing with advance refundings initiated on or after July 1, 1983. Stipulation of Facts & 26. Section 233 does not apply to the advance refunding at issue here. *Id.*

When costs incident to the bond cancellation plus the actual cost incurred on the bond during the provider's reporting period are less than the amount of interest cost and amortization expense that would have been allowable in that period had the indebtedness not been cancelled, then the cost of bond cancellation, to the extent reasonable, is allowable in the year incurred.

Id.

After claiming only part of its reimbursement, the Hospital learned of the decision in *Ravenswood Hosp. Medical Center v. Schweiker*, 622 F. Supp. 338 (N.D. Ill. 1985), in which the court held that Sections 215 and 215.1 are arbitrary and not supported by regulation. Stipulation of Facts & 33. The Hospital then sought to amend its cost report in order to recognize the entire refunding loss in fiscal year 1984. *Id.* By letter dated June 3, 1986 the Intermediary refused to allow the cost report to be amended, and the Hospital subsequently filed a request for a hearing before the PRRB on April 25, 1986. *Id.* In its September 25, 1989 decision, the PRRB agreed with the Hospital that the loss on the advance refunding should be reported in 1984, the year in which it was incurred. *Id.* & 35. The Secretary reversed the PRRB by decision dated November 22, 1989, holding that ' ' 215 and 215.1 required amortization of the advance-refunding loss. *Id.*

The sole issue before the court is one of timing -- when should the costs resulting from the advance refunding be recognized and reimbursed?

III. STANDARD OF REVIEW

Title XVIII sets forth the appropriate standard of review at 42 U.S.C. ' 1395oo(f)(1). Under this section, the court's review of the Secretary's decision in this case falls within the provisions of the Administrative Procedures Act ("APA"), 5 U.S.C. ' ' 701 - 706. Under 5 U.S.C. ' ' 706(2)(A) and (E), the court must determine whether the agency action was arbitrary, capricious, an abuse of discretion, unsupported by substantial evidence or otherwise not in accordance with law. `` It is well-

established that this standard of review is highly deferential, whereby the reviewing court presumes the agency action to be valid." *Conservation Law Found. v. Secretary of the Interior*, 864 F.2d 954, 957-58 (1st Cir. 1989) (citations omitted). The court's role is not to determine what it would decide sitting in place of the agency; rather, it must determine whether the agency's decision can withstand the arbitrary and capricious challenge on review. *Id.* at 958. The court must give considerable weight to the Secretary's interpretation of his own regulations. *McCuin v. Secretary of Health & Human Servs.*, 817 F.2d 161, 168 (1st Cir. 1987). This deferential standard, however, does not make the court's review a meaningless process. The Secretary's interpretation "must be reasonable in view of the language of the regulations and the policies they were meant to implement." *Id.* When, as here, there are conflicting interpretations of the regulations, the court "must try to give [statutes and regulations] a harmonious, comprehensive meaning, giving effect, when possible, to all provisions." *Id.* (citations omitted).

IV. LEGAL ANALYSIS

The plaintiff argues that the Secretary's decision requiring the Hospital to amortize its advance refunding losses is arbitrary and contrary to the Medicare regulations. The plaintiff cites the Secretary's regulations at 42 C.F.R. ' ' 413.20 and 413.24 to support its claim. When Medicare regulations do not specifically address the accounting methods to be used in any given situation, generally accepted accounting principles ("GAAP") may be applied.⁵ 42 C.F.R. ' 413.20(a); *see also* Decision of the

⁵ The United States Court of Claims instructs that

[g]enerally accepted accounting principles consist of the official publications of the American Institute of Certified Public Accountants (i.e. Opinions of the Accounting Principles Board, Financial Accounting Standards Board Statements, and Accounting Research Bulletins). Where there is no official publication, the consensus of the accounting profession, as manifested for example in textbooks,

Administrator, Record at 2, 4-5. The Secretary has not promulgated any regulations specifically dealing with advance refunding losses or establishing when such losses are to be recognized for reimbursement purposes. Stipulation of Facts & 19.

The Accounting Principles Board ("APB") Opinion No. 26, published by the American Institute of Certified Public Accountants, provides that a loss on an advance refunding should be recognized in the year in which the advanced refunding takes place. *Id.* & 22. The Institute considered and rejected proposals that losses on advance refundings should be amortized. *Id.* & 23. Opinion No. 26 established GAAP treatment of advance refunding losses and expressly superseded Accounting Research Bulletin ("ARB") No. 43 which favored amortization of such losses. *Id.* && 22-23.

The Secretary's regulations further require that the provider compile adequate cost data which "must be based on an approved method of cost finding and on the accrual basis of accounting." 42 C.F.R. ' 413.24(a); Stipulation of Facts & 7. Under the accrual method of accounting, "revenue is reported in the period when it is earned, regardless of when it is collected, and expenses are reported in the period in which they are incurred, regardless of when they are paid." 42 C.F.R. ' 413.24(b)(2); Stipulation of Facts & 7. The providers must maintain financial records and statistical data to support their costs-payable data. 42 C.F.R. ' 413.20(a); Stipulation of Facts & 7. In that process, "[s]tandardized definitions, accounting, statistics, and reporting practices that are widely accepted in the hospital and related fields are followed." *Id.*

determines generally accepted accounting principles.

Spokane Valley General Hosp., Inc. v. United States, 688 F.2d 771, 776 n.4 (Ct. Cl. 1982)(citation omitted).

The Hospital asserts that, because the Secretary has not promulgated regulations dealing specifically with advance refunding costs, the above GAAP procedures should be followed, allowing it to claim its entire loss from advance refunding in a single year. The Secretary counters that GAAP principles should not apply in this case and that the refunding losses should be amortized. The Secretary asserts that he must rely upon the policies set forth in the PRM, which call for amortization of costs associated with the recall of debt.⁶ This approach, the Secretary contends, is necessary to avoid a violation of 42 U.S.C. § 1395x(v)(1)(A). That section prohibits "cross-subsidization" -- subsidizing medical-care costs incurred by non-Medicare patients. While recognizing that GAAP procedures are appropriate in most circumstances, the Secretary argues that following GAAP in this case would compromise the Medicare statute by requiring Medicare to reimburse more than its share of the refunding losses in a single cost year. Under the circumstances of this case, the Secretary argues, amortization is not only a permissible and reasonable interpretation of the pertinent statutes and regulations but a necessary one.

A. Cross Subsidization

The underpinning of the Secretary's decision is the statutory prohibition against "cross subsidization." Defendant's Memorandum at 14. The Secretary defines cross subsidization as the process whereby, *inter alia*, a provider seeks reimbursement from the Medicare program for costs incurred by it which are in part attributable to non-Medicare patients or activities. *Id.* at 14-15. This would occur, he argues, when the full reimbursement of costs in a single year exceeds actual Medicare

⁶ As noted above, § 215 and 215.1 of the PRM provided that reimbursement of bond cancellation costs are allowed to the extent that they are reasonable. "Reasonableness" is determined by considering the overall financial implications of the recall. In addition, § 215.1 limited the amount of bond cancellation costs that a provider could claim in any single cost year. Essentially, larger cancellation costs would have to be spread over future years. Both sections have since been replaced by a new § 233 which deals exclusively with advance refunding costs.

costs for that year. Thus, there allegedly would not be a proper "matching" of costs to Medicare reimbursement. The Secretary argues that this result justifies a departure from GAAP, and that the statutory prohibition against cross subsidization can be found at 42 U.S.C. § 1395x(v)(1)(A): "[T]he necessary costs of efficiently delivering covered services to individuals covered by [Medicare] will not be borne by individuals not so covered"

The Secretary purports to have promulgated regulations that implement the statutory prohibition against cross-subsidization at 42 C.F.R. §§ 413.5(b)(3), 413.9(a) and 413.9(b)(1). Section 413.5(b)(3) pertains to general cost reimbursement principles; specifically, it provides that there be a proper division of allowable costs between Medicare and non-Medicare patients. Section 413.9(a) states that "payments must be based on the reasonable costs of services covered under Medicare and related to the care of Medicare beneficiaries." In addition, § 413.9(b)(1) states that the reasonable cost of services "must be determined in accordance with regulations establishing the method or methods to be used, and the items to be included." The Secretary contends that under these regulations payments must be amortized in order to properly reflect the cost of providing services to Medicare beneficiaries. I find that the Secretary's position is not a reasonable interpretation of the Medicare regulations taken as a whole.

The Secretary's cross-subsidization argument rests on a faulty premise. The regulations cited by the Secretary relate to the reasonableness of the claimed costs. There has been no allegation that the Hospital has not properly allocated the claimed costs between Medicare and non-Medicare patients. The parties have agreed that the costs are reasonable and that the only outstanding issue is one of timing: when should the reimbursement be made. This at a minimum suggests that there is no disagreement that the requested reimbursement relates only to health services rendered to Medicare beneficiaries.

I also find that the Secretary's analysis rests on a rather selective reading of the Medicare regulations. He is correct in citing to 42 C.F.R. ' 413.5(b)(3), which states the program objective of maintaining a division of costs between Medicare beneficiaries and other patients. He then argues that this regulation mandates amortization so that the provider is not reimbursed beyond the costs attributable to Medicare patients. However, ' 413.5 must be read in its entirety in order to discern its full meaning. For example, ' 413.5(a) states that, ``[i]n formulating methods for making fair and equitable reimbursement for services rendered beneficiaries of the program, payment is to be made on the basis of current costs of the individual provider" Section 413.5(b)(1) states that ``the methods of reimbursement should result in current payment so that institutions will not be disadvantaged, as they sometimes are under other arrangements, by having to put up money for the purchase of goods and services well before they receive reimbursement."

The Secretary finally argues that the Hospital's loss was not a cash loss but only a ``paper" loss, suggesting that the Hospital has not, in fact, incurred any real costs attributable to Medicare reimbursement. I disagree. The Hospital incurred a larger debt from the second bond issue than from the first, as well as up-front costs related to the transaction. In addition, the loss incurred as a result of the advance refunding has weakened the Hospital's debt-to-equity ratio and may have placed it in a less desirable position for obtaining future financing. Consequently, the Hospital has indeed incurred present debt and related costs.

In *Charlotte Memorial Hosp. & Medical Center, Inc. v. Bowen*, 860 F.2d 595 (4th Cir. 1988), the Secretary asserted that the provider, in claiming reimbursable costs under an employee deferred compensation plan, was requisitioning costs it had not yet sustained. The court found that GAAP did accurately reflect the cost of patient care, determining that a failure to recognize the hospital's present costs or debt ``would disrupt the accurate matching between real costs and reimbursements [and that, as a result, t]he hospital would face a financial strain." *Id.* at 601. Amortizing the costs in the present

case would fail to take account of the real costs immediately incurred by the Hospital as a result of the advance refunding. I find the court's reasoning in *Charlotte Memorial* persuasive and reach the same conclusion here. The Secretary has not shown by substantial evidence that the Medicare regulations cited above mandate amortization in order to match costs with Medicare reimbursement.

B. Provider Reimbursement Manual

Buttressing the Secretary's cross-subsidization argument is his contention that PRM ' ' 215 and 215.1 clarify the meaning of 42 C.F.R. ' ' 413.5 and 413.9 as cited above and also call for amortization of the costs in this case. The Hospital contends that these sections make substantive changes in the Secretary's regulations and are, therefore, invalid under the APA.

As an initial matter, I find that the Secretary's assertion that these PRM sections call for amortization of advance refunding costs involves a rather strained reading of the provisions. Section 215 relates to debt cancellation costs⁷ and determination of reasonable costs:

In determining the reasonableness of the costs of recalling bonds before their maturity, consideration must be given to the overall financial implications of the recall. Financial considerations include not only the fact that more favorable terms can be secured by the provider, particularly with regard to interest rates, but also the cost of debt cancellation. . . .

⁷This section once referred to "costs incident to the recall of bonds." However, the word "bond" was changed to "debt" by amendment. See Exh. B to Defendant's Memorandum.

Section 215.1 details when these costs may be amortized or accrued. The plain meaning of ' 215 makes clear that it relates to the reasonableness of costs. The issue before the court is not one of reasonable costs but rather timing of reimbursement. Further, there is nothing in the language of these PRM sections that relates specifically to advance refunding losses.⁸ Therefore, the Secretary's reliance on this PRM provision is misplaced. One court -- and apparently the only court -- which has published an opinion discussing these specific PRM provisions, struck them down as arbitrary and unsupported by regulation. In *Ravenswood Hosp. Medical Center v. Schweiker*, 622 F. Supp. 338 (N.D. Ill. 1985), the court took note of the provider's contention that the Secretary treated gains and losses on advance refundings differently. That is, when there was a gain, the Secretary did not require amortization, but when there was a loss, he invoked ' 215.1 to require amortization. *Id.* at 344-45. The court, agreeing with the PRRB decision in that case, held that ' 215.1 was arbitrary and not supported by regulation. It found that application of GAAP was the appropriate way to treat the advance refunding losses since

⁸ In fact, when the new PRM ' 233 was issued, the introductory paragraph to PRM ' 215 was changed to state that "[t]his section pertains to a recall of debt before scheduled maturity without the issuance of new debt. For a discussion of the principles of reimbursement pertinent to a repurchase of debt before scheduled maturity accomplished through the use of funds obtained from the sale of other debt securities (advance refunding), see ' 233" See Exh. B to Defendant's Memorandum.

the call premium and refinancing expenses were paid and the loss incurred in the year of refunding. *Id.* at 345.⁹

In his decision, Record at 12, the Secretary states that "Sections 215 and 215.1 of the PRM, as clarified by Section 233, are applicable to the Provider's bond refunding transaction," concluding that those sections together mandate amortization of advance refunding losses. However, the parties have stipulated that "Section 233 does not apply to this case since it post-dates the instant transaction. These PRM sections substantively change the Secretary's accrual regulatory procedures into amortization procedures. The court in *Charlotte Memorial* found that the PRM provisions at issue in that case "cut against the tenor of the applicable regulation, 42 C.F.R. § 413.24. The interpretations, in addition, conflict with the GAAP approach. The Court therefore sets these interpretations aside and applies the GAAP approach to the instant case." *Charlotte Memorial*, 860 F.2d at 602. I concur with that court's findings and conclude, for purposes of this case, that the Secretary's PRM "clarifications" are contrary to the applicable regulations and impermissible under the APA.

The law is well established in this area. The PRM's function is to serve as "a guide for intermediaries in applying the Medicare statute and reimbursement regulations and does not have the binding effect of law or regulation[.]" *National Medical Enters. v. Bowen*, 851 F.2d 291, 293 (9th Cir. 1988) (quoting *Phoenix Baptist Hosp. & Medical Center, Inc. v. Heckler*, 767 F.2d 1304, 1307 (9th

⁹ The Secretary urges this court to give short shrift to the *Ravenswood* decision because the facts are not completely analogous to those of the present case. He also asserts that he would not be inclined to change his policy because of one district court decision. I am not persuaded by his arguments. The *Ravenswood* court spoke directly to the PRM provisions at issue here in the context of an advance refunding. The Secretary's central argument rests on these very provisions. While I agree that the *Ravenswood* decision cannot alone resolve this dispute, it certainly merits due consideration.

Cir. 1985)). It `` does not implement new substantive policy, but rather provides optional guidelines clarifying existing regulations. . . ." *Id.* (quoting *John Muir Memorial Hosp., Inc. v. Schweiker*, 664 F.2d 1337, 1339 (9th Cir. 1981)). Where a PRM provision exceeds its purpose and conflicts with an existing regulation or statute, it is invalid under the APA. *See, e.g., National Medical Enters.*, 851 F.2d at 293 (PRM interpretations hostile to accrual accounting regulations will not be enforced since regulation and not PRM has force of law); *Vista Hill Found., Inc. v. Heckler*, 767 F.2d 556, 559-60 (9th Cir. 1985) (court will defer to Secretary's interpretations only when consistent with statute and regulations); *Fairfax Nursing Center, Inc. v. Califano*, 590 F.2d 1297, 1301 (4th Cir. 1979) (Secretary may not promulgate regulations and then change their meanings by interpretations or clarifications without formal notice or comment.)

The Secretary has explicitly promulgated regulations generally applying GAAP. In those circumstances where the Secretary chooses not to apply GAAP, he is free to promulgate regulations providing for another method of accounting and reimbursement. He has not done so for purposes of this case. It is not difficult to discern that ' 215.1 --as a deviation from GAAP -- flies in the face of the Secretary's own governing reimbursement regulations.

C. Accounting Regulations and Policies

It is particularly difficult for the court to construe the Secretary's position as reasonable when there are GAAP regulations that speak directly to the timing issue presented here. The Secretary acknowledges that he has not published regulations dealing specifically with advance refunding cost reimbursement. He has also acknowledged that GAAP applies in the absence of regulations specifically addressing a particular issue. The Secretary's own regulation at 42 C.F.R. ' 413.20(a) calls for the application of ``widely accepted" principles (GAAP) in the absence of regulations to the contrary. Further, 42 C.F.R. ' 413.24(a) states that reimbursable cost data must be based on the

accrual method of accounting; ' 413.24(b)(2) states that under accrual accounting principles expenses are reported in the period in which they are incurred, regardless of when they are paid.

The Secretary argues that the court should consider the case of *Thor Power Tool Co. v. Commissioner*, 439 U.S. 522 (1979), wherein the Supreme Court allowed the Commissioner to deviate from a GAAP policy that the Commissioner found to be incompatible with income taxation policies.¹⁰ In *Thor*, however, there were no specific regulations in place requiring conformance with GAAP. That is not the case here. I am inclined to agree with the court in *Charlotte Memorial Hosp. v. Bowen*, 665 F. Supp. 455, 458 (W.D. N.C. 1987), which offered a succinct response in a similar situation where the Secretary cited Treasury regulations to support his position opposing reimbursement for a deferred compensation plan:

The Secretary's argument would be persuasive if it has the same regulations that the Treasury has; but, it does not. The only regulation the Secretary has on this point is 42 C.F.R. 413.24(b)(2) [providing for the accrual basis of accounting]. . . .

The Secretary cannot disregard his regulations and adopt those of the Treasury Department without complying with [APA rulemaking procedures].

¹⁰ Other cases urged upon the court by the Secretary to support his position are not helpful. In those cases the Secretary's interpretations did not conflict with GAAP. Amortization or capitalization was allowed because the Secretary's interpretations and GAAP were in accord. Therefore, the court never reached the conflict presented here. *See, e.g., Spartanburg Gen. Hosp. v. Heckler*, 607 F. Supp. 635, 641 (D.S.C. 1985) (PRM provision upheld where it merely clarified GAAP); *Gosman v. United States*, 573 F.2d 31, 41 (Ct. Cl. 1978) (PRM provision at issue conformed with APB opinion regarding amortization of deferred financing charges).

It is hornbook law that an administrative agency is bound by its own regulations and cannot maintain a position contrary to those regulations. . . .

To deny Plaintiff reimbursement on the basis of interpretive rules which are inconsistent with the Secretary's regulations would be tantamount to emasculating the requirements of the statute and result in rule by edict from a government agency.

Another opinion applying the Secretary's accrual accounting regulations in the context of a similar "timing" issue is *Medical Society of South Carolina d/b/a Roper Hospital v. Heckler*, Case No. 83-235-1 (D.S.C., Feb. 27, 1984), reported at CCH Medicare & Medicaid Guide & 33,651 (1984-1 Transfer Binder). The provider in that case argued that sick-pay costs should be reimbursed when they are earned by the employees, even though the employees may not use their accrued sick-pay in the accrual year. The Secretary argued that sick-pay costs were not reimbursable until the employees used their accrued sick-pay. The court found the Secretary's accrual accounting regulations determinative:

The sole dispute involves a question of timing, when these sick-pay costs should be reimbursed. The court finds that the Secretary's regulations requiring accrual accounting do govern the determination of when allowable costs, such as sick-pay costs, are recognized by the Medicare Program.

Id. at 10,089.

Finally, the Court of Appeals for the Fourth Circuit upheld the district court's decision in *Charlotte Memorial* in granting the hospital reimbursement for portions of physician salaries paid under a deferred compensation plan. The Fourth Circuit noted that "[t]his case raises a financial 'timing' question under Medicare regulation 42 C.F.R. ' 413.24" as to when a hospital incurs a reimbursable cost under a deferred compensation plan. *Charlotte Memorial Hosp. & Medical Center v. Bowen*, 860 F.2d at 598. Quoting *Villa View Community Hosp., Inc. v. Heckler*, 720 F.2d 1086, 1093 n.18 (9th Cir. 1983), the court found that "costs shall normally be reimbursed in accordance

with generally accepted accounting principles[.]” *Charlotte Memorial*, 860 F.2d at 599. The court also stated that “a number of cases indicate that the Secretary must follow GAAP in determining cost reimbursement unless the Secretary promulgates a *regulation* delineating a different accounting practice.” *Id.* (citations omitted) (emphasis in original).¹¹

I am also compelled to respond to the Secretary's argument that his accrual accounting regulations apply only to record-keeping practices and do not address when costs will be reimbursed. Defendant's Memorandum at 24. While the Secretary cites *Sun Towers, Inc. v. Heckler*, 725 F.2d 315, 328-29 (5th Cir. 1984), in support of this position, the issue before that court was the allowability of certain costs. The Secretary had found certain costs to be reasonably related to patient care and other costs unrelated. As previously noted, the parties in the present case have agreed that the costs for which the Hospital seeks reimbursement are reasonable. I find the following reasoning much more persuasive in this instance:

The [Secretary's] argument is illogical. The Secretary mandates certain record keeping requirements precisely because the provider is entitled to reimbursement of reasonable costs. . . . To suggest that the Secretary required providers to seek reimbursement under one accounting system while he intended to make payment under another is contrary to the structure of the regulations.

St. Luke's Hosp. v. Secretary of Health & Human Servs., 632 F. Supp. 1387, 1391 (D. Mass. 1986), *vacated on other grounds*, 810 F.2d 325 (1st Cir. 1987).

¹¹ The Fourth Circuit also noted that, even if the Secretary were authorized to prescribe interpretations that conflict with GAAP, “the Secretary would be at the very limit of his authority in doing so. Accordingly, such interpretations would be subject to greater scrutiny than interpretations which are consistent with GAAP” *Charlotte Memorial*, 860 F.2d at 600.

Finally, I note that the Secretary contends that the APB supports amortization of advance refunding losses. In doing so, he summarily rejects APB Opinion No. 26, the standing GAAP policy for treatment of advance refunding losses. That opinion specifically states that gains and losses should not be amortized to future periods. The Secretary nonetheless proffers the rationale of ARB No. 43, which, before being replaced by No. 26 in 1972, apparently expressed a preference for amortizing advance refunding losses. *See* Record at 7. The Secretary notes that the policy of PRM ' ' 215 and 215.1 `` is consistent with the preferred method under ARB No. 43." *Id.* However, ARB No. 43 is no longer the preferred GAAP policy. Recognizing that there may well be disagreement within the accounting profession on this issue, the Secretary undermines his case by citing arbitrarily to a now obsolete opinion in support of his position. *See HCA Health Servs. of Midwest, Inc. v. Bowen*, 869 F.2d 1179, 1182 (9th Cir. 1989)(APB pronouncements are authoritative regardless of disagreement within accounting profession on such pronouncements).

V. CONCLUSION

Given the absence of regulations specific to advance refunding, the presence of regulations regarding the applicability of GAAP, the limitations of PRM interpretations and the current APB pronouncement on GAAP methodology, I find the Secretary's position arbitrary and capricious and unsupported by substantial evidence on this record. Accordingly, I **GRANT** the plaintiff's motion for judgment.

Dated at Portland, Maine this 25th day of April, 1991.

David M. Cohen
United States Magistrate Judge