PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2011-D7

PROVIDER -
Marian Medical Center
Santa Maria, California

Provider No.: 05-0107

vs.

INTERMEDIARY -
BlueCross BlueShield Association/
National Government Services (n/k/a First Coast Service Options – California)

DATE OF HEARING -
March 25, 2008

Cost Reporting Period Ended –
April 23, 1997

CASE NO.: 00-1489

INDEX

ISSUE:

Whether a loss on disposal of assets is required to be recognized by Medicare as a result of the April 24, 1997 statutory merger of the Provider.

MEDICARE STATUTORY AND REGULATORY BACKGROUND:

The Medicare program provides health insurance to the aged and disabled. 42 U.S.C. §§1395-1395cc. The Centers for Medicare & Medicaid Services (CMS), formerly the Health Care Financing Administration (HCFA), is the operating component of the Department of Health and Human Services (DHHS) charged with the program's administration. CMS' payment and audit functions under the Medicare program are contracted to organizations known as fiscal intermediaries. Fiscal intermediaries determine payment amounts due providers under Medicare law and interpretative guidelines published by CMS. See, 42 U.S.C. §1395h, 42 C.F.R. §§413.20 and 413.24.

At the close of its fiscal year, a provider must submit a cost report to the fiscal intermediary showing the costs it incurred during the fiscal year and the portion of those costs to be allocated to Medicare. 42 C.F.R. §413.20. The fiscal intermediary reviews the cost report, determines the total amount of Medicare reimbursement due the provider, and issues the provider a Notice of Program Reimbursement (NPR). 42 C.F.R. §405.1803. A provider dissatisfied with the intermediary's final determination of total reimbursement may file an appeal with the Provider Reimbursement Review Board (Board) within 180 days of the receipt of the NPR. 42 U.S.C. §1395oo(a); 42 C.F.R. §405.1835 (2008).

Under the Medicare regulations in effect during the year in issue, a provider was entitled to claim as a reimbursable cost the depreciation (i.e., the loss of value over time) of property, plant and equipment used to provide health care services to Medicare patients. An asset's depreciable value is initially set at its "historical cost," generally equal to the purchase price. 42 C.F.R. §413.134(b)(1). To determine annual depreciation, the historical cost is prorated over the asset's estimated useful life in accordance with an acceptable depreciation method. 42 C.F.R. §413.134(a)(3). Providers were then reimbursed for a percentage of the annual depreciation based on the extent to which the asset was used for the care of Medicare patients.[1] The difference between an asset's historical cost and accumulated depreciation is referred to as the net book value or depreciated basis.

Because the calculated annual depreciation was only an estimate of the asset's declining value, the regulation at 42 C.F.R. §413.134(f) provided for an adjustment to reimbursable depreciation where a provider incurred a gain or loss on the disposition of a depreciable asset.[2] If an asset was disposed of for less than the depreciated basis calculated under Medicare (net book value), then the asset's actual loss in value (i.e., depreciation) would

[1] The Medicare Act has been amended to change the method of payment for capital assets.

[2] A depreciation adjustment for a gain or loss was removed from the program's regulations effective December 1, 1997.

exceed the depreciation estimated (and reimbursed) for Medicare purposes. Accordingly, the provider would receive additional reimbursement in the form of a depreciation adjustment so that it is compensated for the actual loss in value. Conversely, if a provider received consideration for a disposed asset that was greater than the depreciated basis, then a "gain" had occurred, and the Medicare program would recapture its share of depreciation previously paid to the provider.

Where a provider sells several assets for a lump sum sales price, the regulation at 42 C.F.R. §413.134(f)(2)(iv) requires the determination of the gain or loss (depreciation adjustment) for each depreciable asset by allocating the lump sum sales price among all of the assets sold in accordance with the fair market value of each asset as it was used by the provider at the time of sale.

The regulation providing for gains or losses originally dealt with the disposition of assets through sale, scrapping, trade-in, exchange, donation, demolition, abandonment, and involuntary conversion such as condemnation, fire, theft or other casualty. In 1979 CMS extended the depreciation adjustment to "complex financial transactions" not previously addressed in 42 C.F.R. §413.134(f) by including mergers and consolidations. 42 C.F.R. §413.134(k). A statutory merger between unrelated parties was treated as a sale of assets that would trigger: (1) the revaluation of assets in accordance with 42 C.F.R. §413.134(g), and (2) the realization of gains and losses under the provisions of 42 C.F.R. §413.134(f). However, a statutory merger between related parties would not trigger a depreciation of adjustment. 42 C.F.R. §413.134(k)(2).[3]

Medicare's rules regarding "relatedness," 42 C.F.R. §413.17, state in pertinent part:

> (b) Definitions. (1) Related to the provider. Related to the provider means that the provider to a significant extent is associated or affiliated with or has control of or is controlled by the organization furnishing the services, facilities, or supplies.
>
> (2) Common Ownership. Common ownership exists if an individual or individuals possess significant ownership or equity in the provider and the institution or organization serving the provider.
>
> (3) Control. Control exists if an individual or an organization has the power, directly or indirectly, significantly to influence or direct the actions or policies of an organization or institution.

42 C.F.R. §413.17

In 1987, CMS issued a set of instructions to its fiscal intermediaries on various types of provider organizational structures, the most frequent types of transactions affecting ownership of these structures, and the Medicare reimbursement treatment of such

[3] Citations regarding depreciation are from the 1997 Code of Federal Regulations. These regulations were originally codified under Part 405.

transactions. See, Section 4502 of the Medicare Intermediary manual (MIM) (CMS Pub. 13-4).

Section 4502.1, entitled "Provider Organizational Structures," explains that a corporation can be one of the three basic types of organizational structures, and can be organized either as a for-profit or a not-for-profit entity. Section 4502.6, entitled "Statutory merger," addressed the reimbursement consequences of a merger involving two or more corporations, as follows:

> A statutory merger is the combination of two or more corporations pursuant to the law of the state involved, with one of the corporations surviving the transaction. Medicare program policy permits a revaluation of assets acquired in a statutory merger between unrelated parties, when the surviving corporation is a provider. . . .
>
> EXAMPLE:
>
> Corporation A (a non-provider) signs an agreement of merger consistent with the principles of applicable state law with Corporation B, the provider, with corporation A surviving. Corporation A will be operated as a provider. Corporations A and B were unrelated parties prior to the transaction. . . .
>
> [The fiscal intermediary] determines that the transaction constitutes a CHOW for Medicare reimbursement purposes since corporation A will be operated as a provider. A gain/loss to the seller and a revaluation of the acquired assets to the buyer are computed.
>
> (Emphasis added).

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Marian Medical Center (Provider) was a general acute care hospital located in Santa Maria, California. Prior to the merger on April 24, 1997, the Provider was owned and operated by the Sisters of St. Francis of Penance and Christian Charity, St. Francis Province, a province of an international Franciscan congregation (Sisters of St. Francis). Also prior to the merger, Mercy Healthcare Ventura County (Mercy) was a two hospital system consisting of St. Johns Regional Medical Center and Pleasant Valley Hospital. Catholic Healthcare West (CHW) was the sole corporate member of Mercy.

The Provider, CHW and Mercy entered into an Agreement of Merger creating CHW Central Coast (CHW-CC) on March 15, 1997.[4] Effective April 24, 1997, the Provider, CHW and Mercy entered into a statutory merger pursuant to Chapter 10 of the California Nonprofit Corporation law, with Mercy, renamed CHW-CC, remaining as the surviving corporation. In a separate

[4] Exhibit P-1.

transaction, not contingent or related to the merger into CHW-CC, St. Francis Medical Center of Santa Barbara was also merged into CHW-CC. Thus, upon completion of the two mergers, CHW-CC was a three hospital system whose sole corporate member was CHW.

Prior to the merger, the board of directors and officers of the Provider and Mercy were distinct and did not overlap.[5] Similarly, prior to the merger, the Provider's and CHW's (corporate member) board of directors did not overlap.[6] Following the merger, only one of the Provider's board members joined the CHW-CC board of directors. There were 18 directors on the CHW-CC Board following the merger.[7]

Under the merger agreement, CHW-CC, the surviving corporation, assumed the Provider's liabilities.[8] The assumption of the Provider's liabilities was the sole consideration for the transaction, estimated to be $36.7 million.[9] This was allocated among the Provider's assets as set forth in the Purchase Price Allocation Agreement.[10]

As part of the merger transaction, the Sisters of St. Francis, CHW and Mercy (which became CHW-CC) entered into a sponsorship agreement, effective on the date of the merger. It provided that the Sisters would continue to provide the sponsorship benefits and services to the Provider's community, including consultation, counseling, advocacy, information on charism, personal services of qualified Sisters, and education. The sponsorship fee to the Sisters was 0.125 percent of the budgeted operating expense of the Provider.[11]

With respect to the calculation of loss on disposal of assets, the Purchase Price Allocation Agreement[12] allocated the purchase price based on the fair market value.[13] The allocations were agreed to among the parties to the transaction as set forth in "Exhibit 1" to the Allocation Agreement and based on the February 28, 1997 Unaudited Financial Statements.[14] Prior to the merger, the parties gave notice to the Intermediary that an appraisal would be performed by Valuation Counselors.[15] Because the appraisal was not completed prior to the merger, a draft appraisal was used for the merger. The final appraisal, completed in February 1999,[16] concluded that the market value of the business enterprise of the hospital and affiliates, as of the date of the merger, was between $35.28 million to $38.5 million, with a reproduction cost estimated at $51.15 million.[17]

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[5] Exhibit P-2.
[6] Exhibit P-3.
[7] Exhibit P-4.
[8] Exhibit P-1, Merger Agreement, at paragraph 3.7.3.
[9] Exhibit P-7, Exhibit 1.
[10] Id.
[11] Exhibit P-44 (These payments ranged from approximately $94,000 in 1999 to $180,000 in 2009, Exhibit P-45).
[12] Exhibit P-7.
[13] *Id*. at Exhibit 1.
[14] Exhibit P-6
[15] Exhibit P-9.
[16] Exhibit P-8.
[17] *Id*. See pages 90-93.

While the initial estimate of the assumed liabilities was $36.7 million,[18] subsequent review determined that the amount of assumed liabilities was approximately $32.7 million.[19] The Provider included a calculation for its claim of loss on disposal of assets in its terminating cost report. National Government Services (Intermediary) eliminated the loss pending further documentation from the Provider.

The Provider appealed the Intermediary's adjustments to the Board pursuant to 42 U.S.C. §1395oo and 42 C.F.R. §§405.1835-405.1841 and met the jurisdictional requirements of those provisions.

The Providers were represented by Kathleen Houston Drummy, Esquire, of Davis Wright Tremaine LLP. The Intermediary was represented by Bernard M. Talbert, Esquire, Associate General Counsel, Blue Cross Blue Shield Association.

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that its position regarding the disallowance of the Provider's loss claim is supported by two circuit court cases: *Via Christi Regional Medical Center, Inc. (successor-in-interest to St. Joseph Medical Center, Inc.) v. Leavitt*, 509 F.3d 1259 (10th Cir. Dec. 7, 2007) (*Via Christi*) and *Robert F. Kennedy Medical Center v. Leavitt*, Case No. CV 05-1628 AG (CD Ca Sept. 21, 2006), *aff'd*, 526 F.3d 557 (9th Cir. May 19, 2008) (*Kennedy*). In both of these cases, the Secretary's interpretation that the realization of a gain of loss on a statutory merger requires a "*bona fide* sale" was found reasonable and that a "*bona fide* sale" requires "reasonable compensation" and a "comparison of the sales price with the fair market value of the assets."

The Intermediary asserts that the principle motivations for the merger are presented in the Provider's Board of Director's meeting minutes on December 17, 1996.[20] The objectives included having the hospital stay consistent with the Catholic mission, the need for access to managed care contracts, access to capital and shared administrative resources and group buying power. While not maintaining any involvement in the new organization that can be considered related, the sponsors were concerned about its future governance and bed replacement.[21] With these considerations in mind the Provider was willing to sell its property, plant and equipment to CHW for $300,000, if one accepts the allocation methodology used,[22] even though under the most conservative estimate those assets were valued at $28 million.

The Intermediary maintains that for a loss to be recognized for Medicare purposes, there has to be a *bona fide* sale in an arm's length transaction. In this case, the Intermediary notes that the Provider's motive, though legitimate, did not meet the requirements of a *bona fide* sale because consideration received for the hospital did not come close to the

[18] Exhibit P-7
[19] Tr. at 181 and Exhibit P-37.
[20] *See* Exhibit I-4 at 3.
[21] Tr. at 44.
[22] Tr. at 44-46.

fair market value of the assets. The Intermediary points out that the assets were merely transferred at the existing book value with no adjustment to the value of the assets nor any assessment or evaluation of the collectability of receivables, the funded depreciation amounts or the market value of the property, plant and equipment.[23]

PROVIDER CONTENTIONS:

The Provider contends that the pertinent regulation, 42 C.F.R. §413.134(k)(2)(i), provides that if a merger was between two or more unrelated corporations, the assets of the merged corporation acquired by the surviving corporation may be revalued and generate gains or losses. The parties have stipulated that the merger transaction in this case was not between related parties.[24] 42 C.F.R. §413.134(k)(2)(i) and (ii) distinguishes what the Secretary considers a *bona fide* statutory merger, which is between unrelated parties, from a non-bona fide statutory merger, which is between related parties. The Provider asserts that subsequent attempts by CMS to add additional requirements regarding "*bona fide*" are inconsistent with the overall structure of the regulation and CMS' historical interpretation of determinations of gains/losses and "*bona fide*" in the statutory merger context. The Provider notes that the Secretary first issued regulations allowing depreciation in 1966.[25] In 1977, the regulation was amended to permit revaluation of depreciable assets following a statutory merger between unrelated parties.[26] In 1979, the regulations were changed to recognize the treatment of certain types of disposals of depreciable assets, including "*bona fide* sales."[27] There was no indication in those changes of any intent to apply additional requirements to mergers. Ultimately, Congress eliminated the recognition of a gain or loss on either the sale or scrapping of an asset that occurs on or after December 1, 1997 but did not express any intent to change recognition of gains or losses incurred prior to that date.

The Provider further contends that program guidance supports its interpretation. In a January 24, 1974 letter from Irwin Wolkstein (Wolkstein Letter), a high ranking Medicare official, he confirmed that a statutory merger in which the then-corporate provider does not survive is treated "for program purposes as if it was purchased by the surviving corporation" and that this requires the transferred assets to be revalued. The Provider points out that in *Kennedy Medical Center v. Leavitt*, *supra*, the court also found that a statutory merger does effect a change in asset ownership. The Provider acknowledged, however, that the court found the Wolkstein Letter did not address the issue of whether the *bona fide* sale requirement of 42 C.F.R. §413.134(f) also had to be met for statutory mergers. Two months after issuance of the Wolkstein letter, Morris Older, another a high ranking Medicare official, further indicated that Medicare policy is independent of how a merger transaction is treated for financial statement purposes or for tax purposes. (Older Letter). The Provider asserts that the regulations were changed in 1979 to reflect the policy announced in the Wolkstein and Older Letters.[28] The Secretary

[23] Tr. at 53-55.
[24] Tr. at 8.
[25] 31 Fed. Reg. 14808 at 14810-11 (Nov. 22, 1966).
[26] 42 Fed. Reg. 17485, 17486 (April 1, 1977).
[27] 44 Fed. Reg. 3980 at 3980-84 (Jan. 19, 1979).
[28] 44 Fed. Reg. 6912-6915 (Feb 5, 1979).

stated that in the case of statutory mergers between unrelated parties, assets of the merged corporation were to be revalued because legal ownership changed, and in accordance with Section 413.134(g) gain or loss should be determined under Section 413.134(f).

In a letter dated May 11, 1987, William Goeller (Goeller Letter), the Director of the Division of Payment and Reporting Policy stated as to asset revaluation and determination of gains or losses stemming from mergers between nonprofit organizations:

> Mergers . . . of nonstock, nonprofit providers may give rise to revaluations of assets . . . and/or adjustments to recognize realized gains and losses . . . If the transaction you have described meets the definition of either a statutory merger or consolidation . . . then a revaluation of assets and/or an adjustment to recognize realized gains and losses may occur. To determine whether a revaluation of assets or a gain/loss adjustment will occur, we must turn to the question of whether the assets will be donated or whether any consideration will be exchanged for the assets. . . . (I)f the assets will be exchanged for consideration, a donation would not occur and the consideration given would be the acquisition cost of the assets to the new owner. In a situation where the surviving/new corporation assumes liability for outstanding debt of the merged/consolidated corporations, the assumed debt would be viewed as consideration given. Thus, in a merger or consolidation of a nonprofit corporations in which the surviving or new corporation assumes debt of the merged or consolidated corporations, . . . an adjustment to recognize any gain or loss to the merged/consolidated corporations would be required in accordance with regulations section 42 C.F.R. §413.134(f) . . .

Provider asserts this language reflects the Agency view that if the statutory merger does not involve a donation of assets (where no value was allocable to the depreciated assets) a gain or loss could be recognized.

The Medicare Intermediary Manual (MIM) §4502.6 provides the following:

> Statutory Merger: … Medicare program policy permits a revaluation of assets acquired in a statutory merger between unrelated parties, when the surviving corporation is a provider.

The Provider points out that the surviving corporation, CHW-CC, in this case is a provider.

MIM Section 4502.6 further provides, in relevant part:

> EXAMPLE: Corporation A (a non-provider) signs an agreement of merger consistent with the principles of applicable state law with corporation B, the provider, with corporation A surviving. Corporation A will be operated as a provider. Corporations A and B were unrelated parties prior to the transactions. The transaction is consummated on June 30, 1986. The RO determines that the transaction constitutes a CHOW for Medicare certification purposes and issues the tie-in notice. Corporation B is required to file a terminating cost report for the period ended June 30, 1986. You determine that the transaction constitutes a CHOW for Medicare reimbursement purposes since corporation A will be operated as a provider. A gain/loss to the seller and a revaluation of the acquired assets to the buyer are computed.

Thus, Medicare policy consistently directs that a gain or/loss be computed in the case of statutory mergers between unrelated parties.

The Provider asserts that the Program Memorandum (PM) on which the Intermediary relies, Transmittal No. A-00-76 (October 19, 2000), entitled, "Clarification of the Application of the Regulations at 42 C.F.R. §413.134(l) to Mergers and Consolidations Involving Non-profit Providers" should not apply retroactively. It was issued in October 2000 which was subsequent to the merger in this case and is at odds with the language of the regulation and prior Agency guidance. The Provider states that the Board is not bound by the PM and, because it contradicts previous rules, the Board should not grant it any weight.

The Provider also argues that the regulation at 42 C.F.R. §413.134(f) focuses on actual consideration, not fair market value. The term "*bona fide*" is not defined in the regulation at 42 C.F.R. §413.134(f)(2) and "fair market value" is mentioned only as to allocating the price among assets. If a provider sells multiple assets for a lump sum sales price, then the provider is required to allocate the lump sum sales price among all the assets sold, in accordance with the fair market value of each asset. 42 C.F.R. §413.134(f)(2)(iv). Fair market value is not used to determine whether the transaction or price is "*bona fide*, but as a basis for allocation only.

The Provider also notes that the regulation defines fair market value as:

> . . . the price that the asset would bring by *bona fide* bargaining between well-informed buyers and sellers at the date of acquisition. Usually the fair market price is the price that *bona fide* sales have been consummated for assets of like type, quality, and quantity in a particular market at the time of acquisition.

42 C.F.R. §413.134(b)(2) (emphasis added). The Provider points out that the term "*bona fide* bargaining" is not defined in the regulation but suggests that it pertains to whether the parties are related.

The Provider also contends that the CMS Pub. 15-1 §104.24 does not support the narrow interpretation offered in the PM. It states in relevant part:

> A *bona fide* sale contemplates an arm's length transaction between a willing and well informed buyer and seller, neither being under coercion, for reasonable consideration. An arm's-length transaction is a transaction negotiated by unrelated parties, each acting in its own self interest.

This provision uses the term reasonable consideration but there is no tie to the PM's expectation of fair market value.

The Provider argues that 42 C.F.R. §413.134(b)(8) makes clear that if any amount is paid for an asset, whether in the form of cash, new debt, assumed debt, property or services, then "the payment is considered the purchase price for the purposes of determining allowable historical cost." The notion offered in the PM that only certain prices will be recognized is undercut by the "donation" definition which says that if there is no consideration, there is a carryover basis and no gain or loss is recognized, but if there is any consideration, there is no carryover basis and a gain or loss would be recognized. Even after allocating appropriate value to current assets, a portion of the assumed liabilities remained to be applied to depreciable assets, so no donation may be said to have occurred in this transaction.

Finally, the Provider also contends that, even if the parties had to enter into a *bona fide* sale to claim a loss, they have shown that the consideration in this case was reasonable. The Provider asserts that there was unrebutted evidence that that there was a need to replace a significant portion of its depreciable assets.[29] Furthermore, there was evidence that the Provider's income was trending downward and there were losses in the first two years after the merger.[30] Moreover, unlike in *Kennedy* (for $30 million in consideration, the buyer received $29 million in cash and cash equivalents alone) and *Via Christi* (for $26.1 million in consideration, the buyer received $29 million in cash and cash equivalents alone) where the consideration exchanged barely covered the current assets, the Provider asserts that it received $32.7 million in consideration for $15.9 million in current assets.[31] This higher level of consideration as compared to book value of the current assets distinguishes this case and further supports the *bona fide* nature of the merger.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

After considering the Medicare laws and guidelines, the evidence presented, and the parties' contentions, the Board finds and concludes as follows:

The parties have stipulated that the Provider, Mercy and CHW were unrelated parties as that term is defined under the regulatory provisions of 42 C.F.R. §413.17. The Board

[29] Tr. at 70 and 72-74, Exhibit P-1 at Section 5.4, and Exhibits P-39, P-40, and P-41.
[30] Tr. at 136 and 137.
[31] Provider's Post Hearing Brief at 25.

finds this to be supported by the record in this case. Accordingly, the Board finds that a revaluation of the assets and a recognition of the gain or loss incurred as a result of the merger is required under the plain meaning of 42 C.F.R. §413.134(1)(2)(i).

The parties have not disputed that the transaction at issue was a statutory merger under California law, and that 42 C.F.R. §413.134 "Depreciation: Allowance for depreciation based on asset costs," is applicable. Section 413.134(1)(2) defines a statutory merger as "a combination of two or more corporations under the corporation laws of the State, with one of the corporations surviving." The Provider merged into Mercy (with a subsequent name change to CHW-CC), with the Provider ceasing to exist. As the surviving corporation, CHW-CC acquired all of the assets and assumed all the liabilities associated with the operations of the Provider by operation of law.

Under the regulations at 42 C.F.R. §413.134(1)(2), the effect of a statutory merger on Medicare reimbursement is as follows:

> (i) *Statutory merger between unrelated parties.* If the statutory merger is between two or more corporations that are unrelated (as specified in §413.17), the assets of the merged corporation(s) acquired by the surviving corporation may be revalued in accordance with paragraph (g) of this section. If the merged corporation was a provider before the merger, then it is subject to the provisions of paragraphs (d)(3) and (f) of this section concerning recovery of accelerated depreciation and the realization of gains and losses. . . .

Even though the parties have stipulated that they were not related in this case, the Board will nevertheless comment on this element because the Secretary has taken the position in other cases, e.g., *Kennedy* and *Via Christi*, *supra*, that the phrase "between unrelated parties" requires that the relationships after the merger transaction be examined as well. 42 C.F.R. §413.134(l)(2)(i) states, "if the statutory merger is between two or more corporations that are unrelated . . ." The Board finds this statement unambiguous in its meaning that the related party concept will be applied to the entities that are merging as they existed prior to the transaction. The Board, therefore, concludes that the regulation bars the application of the related party principle to the merging parties' relationship to the surviving entity. In *Via Christi* the court also found that "both the 'plain language' of the regulation, as well as the 'indications of the Secretary's intent at the time of the regulation's promulgation' preclude the Secretary's current interpretation of 42 C.F.R. §413.134(l)(3)." *Id.* at 1274.[32]

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[32] In *Via Christi*, the court referred to the preamble language at 44 Fed. Reg. at 6913; the 1987 Medicare Intermediary Manual; the 1987 Goeller Letter and the 1994 Booth letter as supporting the interpretation that relatedness is determined between the parties prior to the merger. In *Kennedy*, the court did not decide the related party issue because the provider did not meet the *bona fide* requirement and the issue was moot. *Id.* at 563.

With respect to the *bona fide* sale requirement the Board notes that the 9th Circuit Court of Appeals in *Kennedy*, *supra*, (following *Via Christi*, *supra*) held that the Secretary's interpretation, that the realization of gains and losses on a statutory merger requires a *bona fide* sale, is a reasonable construction of the Medicare regulations. In addition, in determining whether a bona fide sale occurred, one must determine whether the consideration was reasonable by comparing the sales price with the fair market value of the assets sold. The decision in *Kennedy* made the following findings:

> The Secretary's interpretation that the realization of gains or losses on a statutory merger requires a "*bona fide* sale" is a reasonable construction of the Medicare regulations. The regulation governing statutory mergers, 42 C.F.R. §413.134(k)(2), incorporates 42 C.F.R. §413.134(f), which lists the categories of asset disposal that trigger readjustment for gains or losses. *See* 42 U.S.C. (sic) §413.134(k)(2)(i) (stating that merged providers are "subject to the provisions of paragraph … (f) of this section concerning … the realization of gains or losses.") A "*bona fide* sale" is the only category listed in § 413.134(f) that arguably applies to a disposal of assets through statutory merger. *See* Id. §413.134(f)(2)-(6); *Via Christi Reg'l Med. Ctr.*, 509 F.3d at 1275. Thus, the Secretary reasonably interpreted these regulations as allowing gains or losses on the disposal of depreciable assets only when the statutory merger qualifies as a "*bona fide* sale."
>
> The Secretary's interpretation that a "*bona fide* sale" requires "reasonable consideration" and a "comparison of the sales price with the fair market value of the assets" also is supported by the text and purpose of the Medicare statutes. Providers are entitled to reimbursement only for the "cost actually incurred" in servicing Medicare patients. 42 U.S.C. §1395x(v)(1)(A). As the Secretary noted when promulgating 42 C.F.R. §413.134(f), "if a gain or loss is realized from [a] disposition, reimbursement for depreciation must be adjusted so that Medicare pays the *actual cost* the provider incurred." See Principles of Reimbursement for Provider Costs and for Services by Hospital-based Physicians, 44 Fed. Reg. 3980 (Jan. 19, 1979) (emphasis added). The Secretary's requirements of "reasonable consideration" and "fair market value" ensure that Medicare reimburses actual costs, instead of providing a windfall to providers.

Id. at 562 (emphasis in original).

The PM is characterized as a clarification of the application of the regulations at 42 C.F.R. §413.134(1) to mergers and consolidations involving non-profit providers. The "application" section of the PM states, "the above cited regulation (42 C.F.R. §413.134) sections are applicable to mergers and consolidations involving non-profit providers." It goes on to state that "[b]ecause the regulations at 42 C.F.R. §413.134(l) were written to address only for-profit mergers and consolidations, certain special considerations must be

regarded in applying that regulation section to non-profit mergers and consolidations." It directs the Intermediary to determine if a *bona fide* sale has occurred.
The PM further directs the Intermediary to determine whether the seller obtained "reasonable compensation" for the depreciable assets as evidence that the sale was *bona fide*. In May, 2000, a *bona fide* sale definition was added to the manual as follows: "a *bona fide* sale contemplates an arm's length transaction between a willing and well informed buyer and seller, neither being under coercion, for reasonable consideration. An arms-length transaction is a transaction negotiated by unrelated parties each acting in its own self interest." The PM's definition of *bona fide* equates "reasonable compensation" with the fair market value of assets.

Because the 9th Circuit Court in *Kennedy* has determined that a *bona fide* sale is necessary for a loss on disposal of assets through a statutory merger to be recognized, and is controlling in this case the Board therefore addresses the application of that principle to the facts in this case as follows:[33]

Under the PM's clarification as published in October 2000, there can be no *bona fide* sale where there is a large discrepancy between the sale price and the fair market value of the assets sold. Under this standard, the Provider's statutory merger was not a *bona fide sale*. First, the evidence is undisputed that the Provider made no attempt to obtain fair market value for its assets on the open market. The record indicates that the Provider sought a merger because of concerns about its future viability as an independent hospital.[34] By merging with a larger entity, the Provider hoped to obtain access to managed care contracts, access to capital, and lower costs by shared administrative services and group buying power.[35] Another of the Provider's principle motivations, however, was to ensure the continuation of the religious mission of the hospital.[36] Testimony at the hearing indicated that the Provider did not consider a merger with other for-profit or not-for-profit organizations because the sponsoring organization of the Provider, the Sisters of St. Francis, wanted to maintain the religious mission of their facility.[37] The Board finds that the Provider did not attempt to obtain fair market value because the criteria it used in selecting a merger partner did not consider obtaining a fair price for its assets. Instead, the Provider accepted the assumption of its debts as the sale price.[38] In addition, the Provider also sought and received assurances about the future operation of the facility including a commitment to a bed replacement project.[39] The Board notes that while the

[33] In prior decisions, the Board found the concept of requiring a merger to conform to an outright sale to be a new substantive requirement. Until 1977, the regulation on depreciation did not specifically include mergers, although it did cover other types of transactions. In 1977, the Secretary proposed adding a section on mergers and consolidations. 42 Fed. Reg. 17486 (April 1, 1977). When mergers and consolidations were added to the list of transactions that could potentially trigger a depreciation adjustment, the preamble to the final regulation used the term "bona fide transaction" rather than "bona fide sale" as used in 42 C.F.R. §405.415(f)(2)(1979). The Board considered this language significant in that it indicates the Secretary did not consider mergers and consolidations as sales.
[34] *See* Exhibit P-38.
[35] *See* Exhibit I-4 at 3.
[36] *See* Exhibit P-38 at 2 and I-4 at 3.
[37] Tr. at 75-78, 113-114.
[38] *See* Exhibit P-1 Merger Agreement, at 3.7.3.
[39] Exhibits P-1 Merger Agreement at 5.4 and I-4 at 9 and Tr. at 72-74 and 113-114.

Provider obtained a draft appraisal,[40] and then a finalized appraisal,[41] of the fair market value of its assets, the appraisals were not used to determine the amount that the Provider received as consideration; instead, it was used as a basis to allocate the sale price to the assets sold in the determination of the loss on disposal of assets.[42] The amount of assumed liabilities in this case was initially estimated at approximately $36.7 million,[43] but was later determined to be approximately $32.7 million.[44] For this consideration, the surviving entity, CHW-CC, received cash and cash equivalent assets worth approximately $15.9 million,[45] plus plant and equipment appraised at $51.1 million under the cost approach; $38.5 million under the market approach and $28.5 million under the income approach.[46] After allocating the consideration received (i.e., assumed liabilities) to the cash assets, the Provider allocated approximately $18,791,000 to its plant and equipment.[47] The Board finds there was no *bona fide* sale because the Provider did not receive "reasonable compensation" for its assets as that term is defined in PM A-00-76. The PM states that if there is a large disparity between the sales price (consideration) and the FMV of the assets that is indicative of a "lack of *bona fide* sale."

DECISION AND ORDER:

The Intermediary's adjustments disallowing the Providers' claimed loss on the disposal of assets are affirmed.

Board Members Participating:

Suzanne Cochran, Esq.
Yvette C. Hayes
Keith E. Braganza, C.P.A.

FOR THE BOARD:

Suzanne Cochran, Esq.
Chairman

DATE: November 03, 2010

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[40] Exhibit P-42.
[41] Exhibit P-8.
[42] Tr. at 203-204.
[43] *See* Exhibit P-7.
[44] Tr. at 181 and Exhibit P-37.
[45] *See* Exhibit P-37.
[46] *See* Exhibit P-8 at 92.
[47] *See* Exhibit P-12.