PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2005-D9

PROVIDER –
Robert F. Kennedy Medical Center
Hawthorne, California

Provider No.: 05-0420

vs.

INTERMEDIARY –
BlueCross BlueShield Association/
United Government Services, LLC--CA

DATE OF HEARING -
January 7, 2004

Cost Reporting Period Ended -
May 30, 1996

CASE NO.: 99-1467

INDEX

ISSUE:

Is a loss required to be recognized by Medicare as a result of the May 30, 1996 merger of the former corporate owner of the Provider into a new corporate owner?

MEDICARE STATUTORY AND REGULATORY BACKGROUND:

The Medicare program was established to provide health insurance to the aged and disabled. 42 U.S.C. §§1395-1395cc. The Centers for Medicare and 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 administering the Medicare program. CMS' payment and audit functions under the Medicare program are contracted out to insurance companies known as fiscal intermediaries. Fiscal intermediaries determine payment amounts due the providers under Medicare law and under interpretive guidelines published by CMS. See, 42 U.S.C. § 1395(h), 42 C.F.R. §§ 413.20(b) and 413.24(b)

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 proportion 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 issuance of the NPR. 42 U.S.C. §1395oo(a); 42 C.F.R. §405.1835.

Under the Medicare statute in effect during the fiscal year at issue, a provider was entitled to claim as reimbursable cost for its outpatient population the depreciation (i.e., the systematic amortization of cost over time) of buildings and equipment used to provide health care to Medicare patients. Regulations provided that an asset's depreciable value was set initially at its "historical cost," generally equal to the purchase price. 42 C.F.R. §413.134(a)(2). To determine annual depreciation, the historical cost was then prorated over the asset's estimated useful life. 42 C.F.R. §413.134(a)(3). Providers were then reimbursed on an annual basis for a percentage of the yearly depreciation equal to the percentage the asset was used for the care of Medicare patients.[1]

Because the calculated annual depreciation was only an estimate, the regulation at 42 C.F.R. §413.134(f) provided for the determination of a depreciation adjustment 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 a "loss" had occurred because the consideration received for the asset was less than the estimated remaining value. In the event of a loss, the Medicare program assumed that more depreciation occurred than was originally estimated, and the provider received additional reimbursement in the form of a depreciation adjustment. Conversely, if a provider received consideration for a disposed asset

[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.

that was greater than the depreciated basis, then a "gain" had occurred, and the Medicare program recaptured its share of previously reimbursed depreciation paid to the provider.

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. 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 gain or loss adjustment.

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.

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Robert F. Kennedy Medical Center (RFK/Provider) is a general acute care hospital located in Hawthorne, California. Prior to May 30, 1996, RFK, a California nonprofit public benefit corporation, owned the hospital's assets. The Provider's sole corporate member was Kennedy Health Services Corporation (KHS), which was also a California nonprofit public benefit corporation. KHS engaged in fundraising activities for RFK. It also owned certain nonprofit properties in Los Angeles County; specifically, a single family dwelling and a condominium interest in a medical office building.[3]

Prior to May 30, 1996, St. Francis Medical Center (St. Francis) owned and operated a hospital in Lynwood, California. It was also a California nonprofit public benefit corporation. Catholic Healthcare West (CHW), a California nonprofit public benefit corporation, was the sole member of St. Francis prior to May 30, 1996. CHW is sponsored by several different Catholic religious orders and operates numerous hospitals throughout California and elsewhere.

In 1994, RFK began considering potential affiliation or merger opportunities with certain health care delivery systems. It considered four different health care systems as potential merger partners, including CHW. In January 1996, RFK began confidential and exclusive negotiations

[3] Merger Agreement, Exhibit. P-7, p.1.

with CHW.[4] In connection with a potential merger with CHW, RFK considered a variety of benefits and risks, including a loss of control over the hospital.[5]

In early 1996, RFK and CHW engaged in negotiations regarding various issues associated with a potential merger. Each party was represented by its own counsel and each party had a special negotiating team. Among the issues negotiated were post-merger governance and operational issues and the price to be paid for the non-hospital assets.[6] The parties agreed that RFK would merge into St. Francis and RFK would no longer exist. St. Francis would then be the surviving corporation. The merger was effective May 30, 1996.[7]

St. Francis survived the statutory merger and changed its name to Catholic Healthcare West Southern California (CHW Southern California). As a result, CHW Southern California became the new corporate owner of the hospital assets and liabilities effective May 30, 1996. Actual legal ownership of the hospital assets was "grant deeded" to CHW Southern California on May 30, 1996.[8] Following the merger, only one member of the former RFK Board of Directors became a voting member of the CHW Southern California 16-member Board of Directors. A second former RFK board member became a non-voting board member of CHW Southern California.[9] A terminating cost report was filed for the provider claiming a loss resulting from the merger in the sum of approximately $4.3 million. The fiscal intermediary audited the cost report and disallowed the loss in total.

By letter dated February 8, 1999, CHW Southern California, the entity surviving the merger, requested a Board hearing regarding various adjustments, including Adjustment No. 42 pertaining to the claimed loss.

The Provider is represented by Patric Hooper, Esquire, of Hooper, Lundy & Bookman, Inc., and the fiscal intermediary is represented by Bernard Talbert, Esquire, of Blue Cross Blue Shield Association.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board, after consideration of Medicare law and guidelines, parties' contentions, and evidence presented, finds and concludes that the Provider is entitled to claim a loss on the disposal of depreciable assets stemming from its merger with St. Francis.

The Intermediary presents three (3) arguments supporting its position that the Provider's loss should not be allowed for purposes of program reimbursement. First, the Intermediary asserts that the Provider and St. Francis were related parties prior to the merger. This relationship would bar the Provider's claim to the loss pursuant to 42 C.F.R. §413.17. Second, the Intermediary argues that, even if the parties were found to be unrelated, the Provider's loss would still be

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4 See Provider Exhibit P-6, p.11.
5 See Provider Exhibit P-6, pp.13-18.
6 See Provider Exhibit P-6, p. 13; Transcript (Tr) at 75-77
7 See Provider Exhibit P-6.
8 See Provider Exhibit P-9.
9 See Provider Exhibit P-7, Tab 4.

unallowable because the merger was not a bona fide transaction pursuant to 42 C.F.R. §413.134(f)(2). Third, under Generally Accepted Accounting Principles (GAAP), this merger would be deemed a pooling of interests with no gain or loss resulting. Notwithstanding these arguments, the Intermediary asserts that if the Board finds the Provider's loss to be an allowable program cost, it must be recalculated to address several concerns.

The Board finds that there is no evidence in the record to support the argument that RFK and CHW were related parties prior to the merger. While it is necessary only to determine whether the parties were related prior to the merger in order to determine whether gain or loss should be recognized, even on a post-merger basis there is no evidence that anyone associated with RFK prior to the merger had the ability to influence or control the decisions of CHW Southern California after the merger. In fact, only one former member of RFK's Board of Directors was included as a voting member on the merged corporation's Board. In addition, 42 C.F.R §413.134(1)(2)(i) states, in part:

> 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.

The Board finds that the plain language of the regulation bars application of the related party principle to the merging parties' relationship following the merger. The Board's conclusion is further buttressed by the Secretary's interpretive guidelines at HCFA Pub. 13-4 §4502.6, which state in part: "Medicare program policy permits a revaluation of assets acquired in a statutory merger between unrelated parties, when the surviving corporation is a provider."

The Board also finds that the Intermediary's argument that the transaction fails the traditional tests of "bona fide" and "arm's length" is without merit. With respect to the concept of a bona fide sale, 42 C.F.R. §413.134(f)(1) and (2), the Board notes that RFK determined on its own initiative that it should seek affiliation with a larger health system. Further, the record indicates that RFK requested and considered proposals from various interested parties considering mergers. Ultimately, an agreement with St. Francis/CHW was pursued and the parties merged.

The Board rejects the Intermediary's position that the merger does not give rise to a gain or loss because it was accounted for as a pooling of interest on the financial statements of CHW Southern California following the merger. The treatment afforded a transaction for financial statement and Internal Revenue Service purposes does not control the treatment required for Medicare purposes. With regard to gains and losses, the provisions of the regulation at 42 C.F.R. §413.134(l) are controlling. Thus, when unrelated corporations merge and a former corporate provider does not survive the statutory merger, a gain or loss is required to be recognized.

The Board observes that the Provider originally used the Accounting Principles Board (APB) methodology to allocate the $32,577,936 consideration which resulted from the merger transaction. That resulted in more of the consideration being applied to current assets and all of the net book value of fixed assets ($11,870,334) being claimed as a loss. The Provider, at the

hearing, stated that it would accept the Board's preferred proportionate value method to allocate costs to various asset values in existence at the time of the merger and subsequently submitted Revised Exhibit P-11 as its revised calculation of the loss. The Board has examined this presentation and finds it to be only partially accurate. The Provider excluded cash and cash investments from the proportionate value method calculation required by 42 C.F.R. §413.134 (f)(2)(iv). The Board finds this approach incorrect, as all assets, including cash and related cash products, need to be subject to the proportionate method. The effect of the Board's decision is to increase the "value" of fixed assets used in the calculation of the loss resulting from the merger. Therefore, the Board requires the Provider and Intermediary to calculate the loss using the proportionate method for all assets as required by 42 C.F.R. §413.134 (f)(2)(iv).

DECISION AND ORDER:

The merger in this case results in a loss under 42 C.F.R. §413.134(f). The loss is calculated using the proportionate value method required by 42 C.F.R. §413.134(f)(2)(iv). The Intermediary's adjustments are modified.

BOARD MEMBERS PARTICIPATING:

Suzanne Cochran, Esquire
Martin W. Hoover, Jr., Esquire
Gary B. Blodgett, D.D.S.
Elaine Crews Powell, C.P.A.
Anjali Mulchandani-West

FOR THE BOARD:

DATE: December 10, 2004

Suzanne Cochran
Chairman