PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2008-D18

PROVIDER –
Mercy Center for Health Care Services
Aurora, Illinois

Provider No.: 14-0174

vs.

INTERMEDIARY –
BlueCross BlueShield Association/
AdminaStar Federal, Inc.

DATES OF HEARINGS –
July 16-18, 2003 and June 4, 2007

Cost Reporting Period Ended -
November 30, 1997

CASE NO.: 01-0801

INDEX

ISSUE:

Whether the Intermediary's adjustment disallowing the loss on disposal of depreciable assets through consolidation was proper.

MEDICARE STATUTORY AND REGULATORY BACKGROUND:

This is a dispute over the amount of Medicare reimbursement due a health care provider.

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 out to insurance companies 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(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 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 issuance of the NPR. 42 U.S.C. §1395oo; 42 C.F.R. §405.1835.

Medicare reimbursement is governed by 42 U.S.C §1395x(v)(1)(A) of the Social Security Act. In part, the statute provides that the "reasonable cost" of any service shall be the actual cost incurred excluding any part of such costs found to be unnecessary in the efficient delivery of needed health services. The implementing regulation at 42 C.F.R §413.9 provides that reasonable cost includes all "necessary and proper" costs incurred in furnishing healthcare services, subject to principles relating to specific items of revenue and cost.

Under the Medicare statute, a provider is 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 to Medicare patients. An asset's depreciable value is set initially 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 one of several methods. 42 C.F.R. §413.134(a)(3).

The calculated annual depreciation is only an estimate of the asset's declining value. If an asset is ultimately sold by the provider for less than the undepreciated basis calculated under

Medicare (equivalent to the "net book value" and equal to the historical cost minus the depreciation previously paid, see, 42 C.F.R. §413.134(b)(9)), then a "loss" has occurred, since the sales price was less than the estimated remaining value. In that event, the Secretary of DHHS (Secretary) assumes that more depreciation has occurred than was originally estimated and, accordingly, provides additional reimbursement to the provider. Conversely, if the asset is sold for more than its undepreciated basis, then a "gain" has occurred, and the Secretary takes back or "recaptures" previously paid reimbursement. 42 C.F.R. §413.134(f)(1).

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. An appropriate part of the purchase price is allocated to "all of the assets sold" regardless of whether they are depreciable or not.

The regulation providing for gains or losses originally dealt with the disposition of assets through sale, scrapping, trade-in, exchange, donation, demolition, abandonment, condemnation, fire, theft or other casualty. In 1979 CMS extended the depreciation adjustment to "complex financial transactions" not previously addressed in subsection 42 C.F.R. § 413.134(f) by including mergers and consolidations. A statutory merger between unrelated parties was treated as a disposition 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 computation. Likewise, a consolidation between two or more corporations that were unrelated resulted in a depreciation adjustment. No revaluation was allowed if related corporations consolidated. 42 C.F.R. §413.134(l)(3)(ii).

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Mercy Center for Health Care Services, Inc. (Provider) was a general, acute care hospital located in Aurora, Illinois. Prior to December 1, 1997, it was a not-for-profit-corporation whose sole member was Mercy Health Corporation which was sponsored by The Sisters of Mercy of the Americas. On November 30, 1997, the Provider consolidated with corporations sponsored by Franciscan Sisters of the Sacred Heart and Servants of the Holy Heart, to create Provena Hospitals, a new non-profit corporation. The consolidation provided for the transfer of substantially all of the Provider's assets to Provena Hospitals. In consideration for the acquired assets, Provena Hospitals agreed to assume the Provider's liabilities.

Concurrent with the consolidation, the Provider ceased to exist, and a final or terminating Medicare cost report was submitted. In this cost report, the Provider claimed a loss on the disposal of its depreciable assets resulting from the consolidation. The loss was represented by the difference between the assets acquired by Provena Hospitals and the

liabilities that it assumed. AdminaStar Federal (Intermediary) reviewed the Provider's cost report and made an adjustment eliminating the loss.

The Provider appealed the Intermediary's adjustment to the Board pursuant to 42 C.F.R. §§405.1835-405.1841 and met the jurisdictional requirements of those regulations. The amount of Medicare funds in controversy is approximately $4,560,457.[1]

The Provider was represented by Robert E. Mazer, Esquire, of Ober, Kaler, Grimes & Shriver. The Intermediary was represented by Bernard M. Talbert, Esquire, Associate Counsel, Blue Cross Blue Shield Association.

BACKGROUND OF THE CONSOLIDATION:

On February 6, 1997, a "Memorandum of Understanding and Confidentiality Agreement" (MOU) was signed on behalf of various entities ultimately involved in the consolidation.[2] The MOU reflected the parties' intention to continue discussions regarding a Master Co-Sponsorship Agreement and set forth the process for further negotiations and interim steps. Further discussions were based on a document entitled "Vision Statement and Co-Sponsorship Collaboration Conceptual Development."[3]

On July 3, 1997, the parties entered into a Master Affiliation Agreement (Master Agreement).[4] The Master Agreement provided for a single Catholic-identified integrated health care delivery system (System), a new parent organization for the system (SYSTEM NEWCO), and a single hospital operating company (HOSPITALCO) which would result from merger, consolidation or asset transfer of the hospitals that were previously part of one of the three systems.[5]

The closing date of the transaction described in the Master Agreement was to be October 31, 1997 or such other date agreed to by the parties, but no later than June 30, 1998 (Exhibit I-5 at 34).

On November 26, 1997, Articles of Consolidation were filed with the Illinois Secretary of State (Exhibit P-3). As a result, effective November 30, 1997, Mercy Center consolidated with corporations sponsored by Franciscan Sisters of the Sacred Heart and Servants of the Holy Heart to create a new corporate entity, Provena Hospitals. By operation of Illinois law, each of the consolidating entities, including the Provider, ceased

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[1] Intermediary Position Paper at 1.

[2] Provider's Post-Hearing Brief at 14. Exhibit I-5 at E referencing: Mercy Center for Health Care Services, Inc., The Sisters of Mercy of the Americas, Franciscan Sisters Health Care Corporation, Franciscan Sisters of the Sacred Heart, ServantCor, and Servants of the Holy Heart of Mary.

[3] Provider's Post- Hearing Brief at 14. Exhibit I-5 at F.

[4] Exhibit I-5.

[5] Exhibit I-5 at 3.

to exist. Their assets and liabilities were transferred to Provena Hospitals, a corporate entity, which came into being as a result of the transaction. On the same day, the three congregations, Sisters of Mercy, Franciscan Sisters of the Sacred Heart, and Servants of the Holy Heart created Provena Health through amendment to the Articles of Incorporation of Mercy Health Corporation**.** Provena Health became the sole corporate member or "parent" of Provena Hospitals.

PARTIES' CONTENTIONS:

The Intermediary originally characterized the consolidation as a "transfer of sponsorship" and disallowed the claimed loss. The Intermediary now contends that the consolidation does not meet the requirements of 42 C.F.R. §413.134(f)(1). In part, the regulation provides for a gain or loss determination when assets are sold, scrapped, demolished or abandoned, or involuntarily converted (e.g., destroyed by fire or stolen). With respect to the instant case, the asset disposition would result from a sale since no demolition, scrapping or abandonment, etc., occurred. However, the asset disposition, or consolidation, cannot be viewed as a sale under the business definition of the term. A seller in a bona fide sale would generally offer the assets for sale in the open market place seeking to get the highest price possible. However, there is no evidence that the Provider offered its assets in the open market place, that either party attempted to value the assets, or that they bargained in good faith over the sales price. Rather, the evidence shows that the Provider's assets were acquired for approximately 42 cents on the dollar of asset value. [6]

The Intermediary also contends that the consolidation was a related party transaction. According to the Intermediary, CMS Pub. 15-1 §1011.1 requires a merger or consolidation to be examined for relationships after the transaction as well as prior to the transaction. This section states: "[i]f a provider and supplying organization are not related before the execution of a contract, but common ownership or control is created at the time of the execution by any means, the supply contract will be treated as having been made between related organizations." The Intermediary also cites to Program Memorandum A-00-76 that was issued on October 19, 2000 and clarified 42 C.F.R. §413.134(l). The Program Memorandum stated, in part, " . . .whether the constituent corporations in a merger or consolidation are or are not related is irrelevant; rather the focus of the inquiry is whether significant ownership or control exists between the corporation that transfers assets and the corporation that receives them."

The Intermediary supports its argument first referring to Provider Exhibit P-5 at 3, entitled "Overview of the proposed transaction between Franciscan Sisters Health Care Corporation, ServantCor, and Mercy Center for Health Care Services." The Intermediary notes the overview's description of the transaction indicates that Provena Health "holds significant governance powers over all parts of the system," and goes on to state that "[m]ost of the initial Board members will be appointed by each of the three religious congregations that will sponsor this new System." Moreover, the overview states that "[t]he local governing bodies in place immediately prior to the transaction will continue

[6] Intermediary's Position Paper at 7.

as the governing bodies following the transaction," and "[a]t present, all facilities will continue to operate after the transaction the same as they presently do, with the present owners remaining as a component of the new system."

Next, the Intermediary notes that four members of the Provider's Board of Directors became members of the Board of Directors of either Provena Health or Provena Hospitals; three members of the Board of Directors of Franciscan Sisters Health Care Corporation became members of the Board of Directors of either Provena Health or Provena Hospitals; two members of the Board of Directors of ServantCor became members of the Board of Directors of either Provena Health or Provena Hospitals; and three additional members of the Board of Directors of either Provena Health or Provena Hospitals who were members of their respective sponsoring boards prior to the consolidation. In addition, the Provider's president prior to the consolidation became the president of Provena Hospitals, the CEO of Provena Health had been the CEO of Franciscan Sisters Health Care Corporation, and the president and COO of Provena Health was formerly the CEO of ServantCor.[7] In summary, the Intermediary asserts that because the same sponsoring order and directors negotiated the consolidation and then transferred to the boards of the newly consolidated entities, an arms-length transaction did not occur.

The Provider contends that according to 42 C.F.R. §413.134(l)(3)(i) a consolidation between unrelated corporations occurs if the parties are unrelated prior to the transaction. The Provider cites to section 4502.7 of Medicare's Part A Intermediary Manual (CMS Pub. 13-4) providing an example of consolidating entities, unrelated through common ownership or control prior to the consolidation, which results in a gain or loss calculation to the seller.[8]

The Provider also contends that the Intermediary's "continuity of control" argument is contrary to longstanding agency intent and policy interpretations.[9]

The Provider asserts that even if "continuity of control" were a valid application of Medicare's related party principles, it does not exist in the instant case. According to 42 C.F.R.§413.17(b), related party principles apply where there is common ownership or control. Control exists where "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." For example, after the consolidation, Provena Hospitals' nine-member Board of Directors included only one individual who had previously served on the Provider's (or Mercy Health's) board, and Provena Health's nineteen-person board included three former members of the Provider's (and Mercy Health's) board. Finally, as a Class B Member of Provena Health, the Sisters of Mercy had only two rights: to

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[7] Intermediary Position Paper at 11.

[8] Provider's Post Hearing Brief at 22-23, Exhibit P-6.

[9] CMS Pub. 13-4 §4502.7, Exhibit P-6. See also, Director, Office of Payment Policy letter, August 24, 1994 (Exhibit P-25) and Intermediary letter, May 16, 1994 (Exhibit P-29).

appoint two of the six members of the Class D body, and to approve the sale of excess stable patrimony. It had no rights related to the ongoing use of the assets of Provena Hospitals. Therefore continuity of control did not exist with regard to the rights of the Sisters of Mercy.

The Provider also contends that the regulatory requirements for a bona fide sale do not apply to consolidations, nor is there a requirement for "reasonable consideration in order for a consolidation to be a bona fide transaction." The subject transaction was a consolidation under state law; it was not a sale of assets which is a fundamentally different type of transaction. The pertinent regulations make no mention of a requirement that consolidations between unrelated parties be a bona fide sale before a gain or loss can be recognized. Importantly, the Provider was unable to compete in the market place since its facilities were old and run down, it was operating at 50-55 percent capacity, and its financial performance was deteriorating. The Intermediary's assertion that the Provider assets were sold at 42 cents on the dollar does not reflect the assets' deteriorated fair market value.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

After consideration of Medicare law and guidelines, parties' contentions and evidence presented, the Board finds and concludes as follows:

Effective on November 30, 1997 the Provider consolidated with health care corporations sponsored by Franciscan Sisters of the Sacred Heart and Servants of the Holy Heart creating a new corporate entity, Provena Hospitals, with the pre-existing entities ceasing to exist. Under the terms of the transaction, Provena Hospitals acquired all of the assets and assumed all of the liabilities associated with the operation of the Provider and the other consolidating corporate health care entities. The parties agree that the transaction at issue was a consolidation under Illinois State law and that regulation 42 C.F.R. §413.134, "Depreciation: Allowance for Depreciation Based on Asset Costs," is applicable.[10] Section 413.134(1)(3) defines a consolidation as "the combination of two or more corporations resulting in the creation of a new corporate entity."

The Medicare regulation at 42 C.F.R. § 413.134(1)(3) provides for the reimbursement effect of a consolidation, as follows:

> [i]f at least one of the original corporations is a provider, the effect of a consolidation upon Medicare reimbursement for the provider is as follows:

[10] While the Board is aware that the regulation on consolidations may be interpreted as applying only to stock transactions, CMS interprets the regulation to apply to non-profit transactions as well. HCFA's Director of the Division of Payment and Reporting Policy, Office of Reimbursement Policy, stated in a 1987 letter that the regulation applied to non-profits. See, Exhibit P-24. In addition, the October 2000 "Clarification of the Application of the Regulations at 42 C.F.R. § 413.134(1) to Mergers and Consolidations Involving Non-profit Providers," HCFA Program Transmittal A-00-76, states that the regulation applies to non-profits; however, "special considerations" apply. See, Exhibit I-20.

> *(i) Consolidation between unrelated parties*. If the consolidation is between two or more corporations that are unrelated (as specified in §413.17), the assets of the provider corporation(s) may be revalued in accordance with paragraph (g) of this section.
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> (ii) *Consolidation between related parties*. If the consolidation is between two or more related corporations (as specified in §413.17), no revaluation of provider assets is permitted.

Accordingly, the initial question to be addressed in this case is whether or not the subject consolidation is a related party transaction. Medicare rules regarding related parties at 42 C.F.R. §413.17, state in relevant 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.
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> (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.

Based upon an analysis of the facts, the Board concludes that the consolidation is, in fact, a related party transaction as that term is defined and applied under the regulatory provisions of 42 C.F.R. §413.17 and 42 C.F.R. §413.134. Therefore, a revaluation of assets and recognition of a gain or loss as a result of the transaction is not permitted pursuant to 42 C.F.R. §413.134(l)(3)(ii).

The record shows that the consolidation at issue in this case was a multi-tiered transaction. The sponsors' hospitals, clinics, and medical centers were included in Provena Hospitals, while Provena Ventures, Inc. was created to primarily manage insurance products, and Provena Senior Services included the sponsors' long term care and residential facilities. Notably, the pre-transaction sponsors became Provena Health, the sole corporate sponsor or parent of the post-transaction Provena Hospitals.

Unique to this case, as opposed to other consolidation cases that have been before the Board, is the fact that the Provider's relationship with its parent, Mercy Health Care Corporation, remained unchanged throughout the transaction. As discussed above, the three sponsoring congregations created Provena Health as the sole corporate member or parent of Provena Hospitals, which includes the Provider. Provena Health, however, was

created through amendment to the Articles of Incorporation of Mercy Health Corporation.[11] Based upon the perpetuity and authority granted a "corporation," Mercy Health Corporation and Provena Health are the same corporate entity.

Black's Law Dictionary, Fifth Edition defines a "corporation" as follows:

> [a]n artificial person or legal entity created by or under the authority of the laws of a state or nation. . . . Such entity subsists as a body politic under a special denomination, which is regarded in law as having a personality and existence distinct from that of its several members, and which is, by the same authority, vested with the capacity of continuous succession, irrespective of changes in its membership, either in perpetuity or for a limited term of years, and of acting as a unit or single individual in matters relating to the common purpose of the association, within the scope of the powers and authorities conferred upon such bodies by law. . . .

Testimony elicited at the hearing substantiates the proposition that Mercy Health Corporation continued to exist. The Provider's witness, an attorney qualified by the Board as an expert on the organization of nonprofit entities under Illinois State law and the application of Illinois law to changes of ownership transactions, responded to the following question:

> Q. Under Illinois law, would Provena be considered a new corporation?
>
> A. Provena Health, technically, under Illinois law, would not be considered a new corporation.

Transcript (Tr.), July 16, 2003, at 147, Line 13

In summary, Medicare regulations at 42 C.F.R. §413.17 addressing related party transactions, and those at 42 C.F.R. § 413.134(1)(3) regarding consolidations are clear. If a consolidation occurs between two or more parties related through common ownership or control, no revaluation of assets is permitted. With respect to the instant case, Mercy Health Corporation maintained extensive reserve powers over the Provider prior to November 30, 1997, the effective date of the consolidation. And, even though the Provider consolidated with other health care facilities creating a new corporation, (Provena Hospitals), the Provider was essentially controlled by, and able to negotiate

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[11] The Provider states: "On the same day, the three congregations. . . created Provena Health through amendment to the Articles of Incorporation of Mercy Health Corporation. . . . The attorneys determined that while they could create a new entity 'from scratch' it would be more expeditious to "retool" Mercy Health Corporation's corporate documents, including restating the entire substance of its Articles of Incorporation and creating new bylaws. This would avoid the need for a new filing in the Catholic Directory which otherwise would have been required to obtain tax-exempt status for the entity." Provider's Post-Hearing Brief at 16. Exhibit P-4.

prior to the transaction with the same entity that became its controlling parent after the consolidation.

The Board emphasizes that its conclusion in this case does not reflect the Intermediary's continuity of control argument, i.e., that 42 C.F.R. §413.134(l)(3) requires a related party determination to be based upon relationships established after a transaction as well as prior to a transaction. Rather, the Board's findings are based upon the relationship of the Provider to its parent prior to the subject consolidation, albeit, with their parallel move to the Provena system.

DECISION AND ORDER:

The Intermediary's adjustment disallowing the loss claimed by the Provider on the disposal of depreciable assets through consolidation was proper. The Intermediary's adjustment is affirmed.

Board Members Participating:

Suzanne Cochran, Esq.
Elaine Crews Powell, C.P.A
Anjali Mulchandani-West, C.P.A.
Yvette C. Hayes
Michael D. Richards, C.P.A.

FOR THE BOARD:

Suzanne Cochran, Esq.
Chairperson

DATE: February 15, 2008