PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2009-D23

PROVIDER -
Jeanes Hospital
Philadelphia, Pennsylvania

Provider No.: 39-0080

vs.

INTERMEDIARY -
Wisconsin Physicians Service
(Formerly Mutual of Omaha Insurance Company)

DATE OF HEARING -
October 30, 2007

Cost Reporting Period Ended -
June 30, 1996

CASE NO.: 99-0584R (On Remand)

INDEX

ISSUE:

Whether the Jeanes Hospital merger was a bona fide sale.

MEDICARE STATUTORY AND REGULATORY BACKGROUND:

This is a dispute over the amount of Medicare reimbursement due a provider of medical services.

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

Medicare reimbursement is governed by 42 U.S.C. §1395x(v)(1)(A). In part, the statute provides that the "reasonable cost" of any service shall be the actual cost incurred but 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.

Under the Medicare regulations in effect at the time of this dispute, 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 acquisition cost to the present owner. 42 C.F.R. §413.134(b)(1). To determine annual depreciation, the historical cost is prorated over the asset's estimated useful life using 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 sold by a provider for less than the net book value (i.e., the historical cost

minus the depreciation recognized under the Medicare program, see, 42 C.F.R. §413.134(b)(9)), then a loss is deemed to have occurred. In that event, the Medicare program assumes that more depreciation cost has been incurred 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 Medicare program 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.

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:

Jeanes Hospital (Provider) was a general, short-term, acute care facility located in Philadelphia, Pennsylvania. On July 1, 1996, it merged with Temple Central Hospital, Inc. (Temple), a subsidiary of Temple University Health System, Inc.[1] Pursuant to the terms of the merger, Temple acquired all of the Provider's assets, assumed all of its liabilities, and agreed to make a contribution of $1 million to the Anna T. Jeanes Foundation, which, under a different name, controlled Jeanes Hospital prior to the merger. Upon completion of the merger the Provider submitted a terminating Medicare cost report for its fiscal year ended June 30, 1996, in which it claimed a loss on the disposal of its depreciable assets resulting from the merger. However, Mutual of Omaha Insurance Company (Intermediary)[2] concluded that the merger was a transaction between related parties and was not a *bona fide* sale.

[1] Temple was the surviving corporation and was renamed Jeanes Hospital after the merger.
[2] Wisconsin Physicians Service replaced Mutual of Omaha Insurance Company as the Provider's Intermediary.

The Provider appealed the Intermediary's disallowance to the Board. In PRRB Dec. No. 2003-D62, the Board reversed the Intermediary's decisions, concluding that the parties to the merger were unrelated as that term is used in 42 C.F.R. §413.134, thus revaluation of assets and recognition of gain or loss incurred as a result of the merger is required. The Board further found that the merger was a *bona fide* transaction, conducted at arms' length, and remanded to the Intermediary for a calculation of the loss.

The CMS Administrator reversed the Board's decision and denied the Provider's claimed loss. The Administrator found that because a significant number of members from the Provider's board of directors transferred to the surviving entity and because senior officers of the Provider continued as senior officers of the post-merger hospital, there was continuity of control between the Provider and the surviving entity. The Administrator also found that the transaction was not at arms' length because the Provider did not seek to maximize the payment it would receive for its assets through a merger partner. The Administrator found that the amount of consideration received by the Provider reflected a "lack of motivation" to seek payment, and the large loss incurred did not support a finding that the transaction was a *bona fide* sale.

The Provider appealed the Administrator's decision to the U.S. District Court for the Eastern District of Pennsylvania. That Court reversed the Administrator's decision that the parties were related but it remanded the case for further fact finding on the fair market value of the depreciable assets, necessary to a determination of whether a *bona fide* sale occurred.

The court stated:

> [c]omparing the consideration received with the net book value flatly contradicts the Medicare statutes. Rather, the Administrator should have compared the consideration with the fair market value of the assets. Given that the record was never developed on the issue of fair market value, however, the Administrator could not even have reached this determination.
>
> Without any analysis in the record regarding the fair market value of Jeanes Hospital at the time of the merger, this Court cannot determine whether the Jeanes Hospital merger was a *bona fide* sale.

The court concluded by remanding the case to the Administrator for further fact finding to establish the fair market value of Jeanes Hospital at the time of the merger.

The Provider is represented by Terry S. Coleman, Esquire, of Ropes & Gray LLP. The Intermediary is represented by Byron Lamprecht and Terry Gouger, of Mutual of Omaha.

MEDICARE PROGRAM GUIDANCE:

Relevant to this remand is the definition of "*bona fide* sale" as that term pertains to gains and losses from the disposal of depreciable assets. Medicare's Provider Reimbursement Manual, Part I (CMS Pub. 15-1) §104.24 states:

> [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.

Program Memorandum No. A-00-76 provides:

> Appraisals may be relied on to establish the fair market value of depreciable assets. (See PRM [CMS Pub. 15-1] §134ff.) However, caution must be taken in evaluating the appropriateness of the valuations established by appraisal for the purpose of this comparison.
>
> The three most common valuation methodologies are the "cost approach," the "market approach," and the "income approach." A single appraisal may use one or more of these methodologies to arrive at a valuation of the entity. The cost approach is the only methodology that produces a discrete indication of the value for the individual assets of the business, and thus, is the approach that is used to allocate a lump sum sales price among the assets sold. (See 42 CFR §413.134(f)(2)(iv).) The market approach produces an estimate of value by comparing the entity being valued to sales of similar businesses. The income approach produces a valuation through analysis of the predicted future stream of income. Both the market approach and the income approach produce a valuation of the business enterprise as a whole, without regard to the individual fair market values of the constituent assets. As a result, both the market approach and the income approach could produce an entity valuation that is less than the market value of the current assets. Moreover, the income approach has minimal application in the non-profit sector because 1) earnings are often understated due to charity care, pricing limitations, and government regulations, and 2) the approach uses complex formulae that include some factors that are of questionable use in valuing non-profit entities (e.g., common stock risk premium). For the foregoing reasons, the cost approach is the most appropriate methodology to be used in establishing the fair market value of the assets sold for the purpose of comparison with the sales price in a *bona fide* sale analysis. (Emphasis added.)

PROVIDER'S CONTENTIONS:

The Provider contends that because the transaction at issue, a statutory merger, is governed by a specific regulation that dictates the recognition of a loss on the merger transaction, 42 C.F.R. §413.234(l), the merger is not required to meet the *bona fide* sale criteria addressed in 42 C.F.R. §413.134(f)(2).

The Provider also notes that prior to 2000, no definition of "*bona fide* sale" could be found in CMS interpretative manuals. The Provider contends that even under CMS program instructions issued in May 2000 at Pub. 15-1 §104.24, its merger transaction with Temple meets the standards for a *bona fide* sale. The facts of the Provider's negotiations with Temple demonstrate the merger was an arm's length transaction; that is, the Provider and Temple were pursuing their independent interest in agreeing to the terms of the merger. Testimony elicited at the Board's hearings in 2002 and 2007 show that changes in the health care industry fueled Provider's concern for its survival and motivated its efforts to become part of a larger health care system. [3] Also the evidence shows that the Provider negotiated with a number of healthcare systems before the Temple transaction and they did bargain over sale price.[4]

The Provider contends that its merger with Temple meets the CMS Pub. 15-1 §104.24 requirement that the consideration paid for its assets be "reasonable." Consistent with the provisions of Program Memorandum No. A-00-76, there is little disparity between the consideration paid for the assets and their fair market value. The Provider explains that, as of June 30, 1996, the fair market value of its current and other financial assets was $41,869,000.[5] Valuation Counselors, Inc., appraised the market value of its other assets as of June 30, 1996, under the cost approach, the sales comparison approach, and the income approach, and concluded that the fair market value was $30,100,100.[6] Therefore, the appraised fair market value of the total assets at issue was $71,969,000, which approximates the total consideration of approximately $69,000,000 paid by Temple.[7]

The Provider acknowledges that Valuation Counselors' conclusion was based upon the income and sales comparison approaches to appraising assets rather than the cost approach, contrary to PM A-00-76. However, according to Valuation Counselors:

> [t]he Sales Comparison and Income Approaches theoretically provide the best indications of Jeanes Health Systems business enterprise value, with the value derived under the Income Approach being considered the more reliable indicator of value. However, the values derived under the Sales Comparison Approach do provide

[3] Provider's Post Hearing Brief on Remand at 9-11.
[4] Provider's Post Hearing Brief on Remand at 12-13.
[5] Provider's Post Hearing Brief on Remand at 20

[6] Provider's Post Hearing Brief on Remand at 18.
[7] Provider's Post Hearing Brief on Remand at 17

> some corroborative evidence of the value of the business. Accordingly, in determining our conclusion of value, we have incorporated consideration of the values determined under both the Sales Comparison and Income Approaches.[8]

INTERMEDIARY'S CONTENTIONS:

The Intermediary argues that Program Memorandum, HCFA Pub. 60A, Transmittal No. A-00-76, issued by CMS on October 19, 2000, explains, in part, that a merger or consolidation must involve a *bona fide* sale in order to result in a gain or loss determination. Evaluating whether a *bona fide* sale has occurred requires a comparison of the sales price to the fair market value of the assets sold. A large disparity between the sales price (consideration) and the fair market value of the assets sold indicates a lack of a *bona fide* sale.

The Intermediary contends that the Provider has not produced adequate documentary evidence to show that the subject merger was an arms' length transaction and was an otherwise *bona fide* sale. When asked to furnish documentary evidence regarding its negotiations and/or merger discussions with other potential buyers, the Provider furnished limited correspondence pertaining only to the University of Pennsylvania Health System. Moreover, the Provider did not provide any documents relating to the establishment of the sales price, or items referenced in the affiliation agreement to the merger such as regulatory approvals, opinions of counsel, and other elements of due diligence.[9]

The Intermediary also points out that there was no appraisal of the Provider's facilities prior to the merger. Therefore, the Intermediary questions the propriety of the appraisal at issue. Testimony elicited from the Provider's own witness shows that the appraisal that was performed was not based on the cost approach and therefore did not measure the fair market value of each of the Provider's assets as required by 42 C.F.R. §413.134(f)(2)(iv).[10]

Finally, the Intermediary contends that the disparity between the consideration paid for the Provider's assets and the book value of those assets indicates a lack of a *bona fide* sale according to Program Memorandum No. A-00-76. Temple assumed approximately $68,000,000 of the Provider's debt and paid $1,000,000 in cash for assets with a net book value of $103,403,000 per the Provider's financial statements.[11]

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

After considering the Medicare law and guidelines, the parties' contentions, and the evidence presented, the Board finds and concludes that the consideration received by the

---

[8] Exhibit (Ex.) P-35 at 113.
[9] Intermediary's Position Paper on Remand at 5-6.
[10] Intermediary's Post Hearing Brief on Remand at 6.
[11] Intermediary's Position Paper on Remand at 8.

Provider for its assets through statutory merger with Temple was reasonable when compared to the fair market value of those assets. Therefore, a loss claimed by the Provider based on the disposal of its depreciable assets resulting from the merger is proper.

The Board's analysis relies on a comparison of fair market value and the consideration paid. 42 C.F.R. §413.134(b)(2) defines fair market value as:

> (2) *Fair market value*. Fair market value is 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.

The record shows that the Provider and Temple were well-informed buyers and sellers with each pursuing their own interests through extensive negotiations. Testimony elicited at the hearing shows that excess hospital capacity and a move toward large integrated health care systems in Philadelphia in the mid-1990s created competitive pressures among health care providers. These pressures put the Provider's financial survival at risk and resulted in its decision to affiliate with a health care system. The Provider discussed a transaction with the Allegheny Health System, the University of Pennsylvania Health System, the Jefferson Health System and the Albert Einstein Healthcare Network. Negotiations with the University of Pennsylvania resulted in the signing of a memorandum of understanding to merge. However, negotiations ultimately failed, and the affiliation agreement with Temple was then pursued. Temple was drawn to the merger by its own business plan to build a health care system.

The record indicates a lengthy negotiation between the parties as to the acquisition price for the Provider's operation. Temple's Chief Financial Officer testified that Temple took the position that it should not have to absorb the Provider's liabilities in light of the value of its assets, and that the Provider argued to the contrary.[12] In reaching the merger terms, Temple carefully determined that the expected income from the Provider's operations would be sufficient to cover the payment made to the Anna T. Jeanes Foundation and the liabilities that would be assumed. To assess whether it was paying a fair market price for the Provider, Temple performed due diligence on the income streams and the expenses as well as the underlying assets themselves to ensure that there would be sufficient revenue to cover the debt service and expenses. Based on the above evidence, the Board finds that the fair market value of the Provider's assets is $69,214,000 (i.e., $68,214,000 in liabilities assumed by Temple plus $1,000,000 paid to the Anna T. Jeanes Foundation) because that price was the outcome of *bona fide* bargaining at arm's length between well-informed parties each acting in its own self interest.

The Board's position is further supported by an appraisal of the Provider's assets performed by an independent appraisal company. Approximately two months after the

[12] October 30, 2007 Transcript (Tr.) at 108.

date of the merger, Valuation Counselors concluded that the fair market value of the Provider's land and depreciable assets was $30,100,000.[13] Since the value of the Provider's cash and other current assets was approximately $41,869,000 at that date, the total appraised fair market value of the Provider's assets was $71,969,000. Clearly, there is little disparity between the fair market value determined by appraisal and the consideration of $69,214,000 paid by Temple.

The fair market value determined by Valuation Counselors was based upon the income approach (an estimate of future earnings) for appraising assets and the market or sales comparison approach (the sales value of similar businesses) rather than the cost approach recommended by CMS (see Program Memorandum No. A-00-76). Based upon its experience and expertise, Valuation Counselors concluded "[t]he Sales Comparison and Income Approaches theoretically provide the best indications of Jeanes Health Systems business enterprise value . . ."[14] The cost approach uses straight-line depreciation based on the replacement value of the assets. It does not take into account functional and economic obsolescence which accounts for the difference in values reflected by the cost and income approaches.

Valuation Counselors also explained that its appraisal of the Provider's land and depreciable assets specifically conformed to 42 C.F.R. §413.134(b). As noted above, this regulation defines fair market value (in part) as "the price that *bona fide* sales have been consummated for assets of like type, quality, and quantity in a particular market." Valuation Counselors' conclusion that the fair market value of the Provider's land and depreciable assets, based upon the sales of like facilities, ranged between $29,400,000 and $31,850,000, provides corroborative evidence that the fair market value of the Provider's land and depreciable assets totals $30,100,000 using the income approach.[15]

Valuation Counselors also determined the fair market value of the Provider's land and depreciable assets using the cost approach. However, this approach was to be used only to meet the requirements of 42 C.F.R. §413.134(f)(2)(iv), which requires a gain or loss on the disposal of each depreciable asset be determined by a pro rata allocation of the lump sum sales price among all assets sold based on the fair market value of each. The cost approach method of appraising assets generally establishes the reproduction cost of assets as new, and adjusts (reduces) that cost for physical deterioration, but not for functional obsolescence and economic obsolescence. While Valuation Counselors established the reproduction cost of the Provider's assets, it adjusted these costs only for physical deterioration. Because functional and economic obsolescence were not taken into account, the fair market value using the cost approach ($48,808,000) is greater than the value determined under the income approach ($30,100.000).[16]

Based upon a careful review of Valuation Counselors' appraisal, the Board finds that the fair market value of the Provider's land and depreciable assets is $30,100,000. That

[13] Exhibit P-35.
[14] Exhibit P-35 at 113.
[15] Exhibit P-35 at 113.
[16] Exhibit P-35 at 22.

together with the fair market value of the Provider's cash and other current assets closely approximate the total consideration paid of $69,214,000.

The Board notes the Intermediary's contention that the disparity between the consideration paid for the Provider's assets and the book value of those assets (per the financial statements) indicates a lack of a *bona fide* sale according to Program Memorandum No. A-00-76. The Court specifically addressed this argument, stating:

> The Administrator's decision concluded that the transaction was not an arm's-length transaction because the assumption of the debt and payment of $1 million, equivalent to a total of $69,214,000 in consideration, was insufficient consideration for an asset with a total net book value of $98,708,000. The Court finds this conclusion to be clear error, and therefore arbitrary and capricious. Comparing the consideration received with the net book value flatly contradicts the Medicare statutes.

The Board is aware that the net book value of land and fixed assets can be substantially different from fair market value, since net book value is based on historical cost and straight line depreciation, with no recognition of functional or economic obsolescence.

DECISION AND ORDER:

The consideration received by the Providers, $69,214,000 was reasonable when compared to the fair market value of its assets which does not exceed $71, 969,000 as determined by the appraisal. Depreciable assets and land comprises $30,100,000 of that value.

BOARD MEMBERS PARTICIPATING:

Suzanne Cochran, Esquire
Yvette C. Hayes
Michael D. Richards, C.P.A.
Keith E. Braganza, C.P.A.

FOR THE BOARD:

Suzanne Cochran, Esquire
Chairperson

DATE: May 27, 2009