PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2011-D23

PROVIDER –
Memorial Hermann Hospital
Houston, Texas

Provider No.: 45-0068

vs.

INTERMEDIARY -
BlueCross BlueShield Association/
Trailblazer Health Enterprises, LLC

DATE OF HEARING -
November 17-18, 2009

Cost Reporting Period Ended -
November 3, 1997

CASE NO.: 05-0476

INDEX

ISSUE:

Whether the Intermediary properly disallowed the loss claimed by Hermann Hospital representing a complete write-off of the book value of its depreciable assets as a result of the merger with the Memorial Hospital System.[1]

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 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 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.

42 U.S.C. §1395x(v)(1)(A) 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 states 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 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 to Medicare patients. An asset's depreciable value is its "historical cost," which is the cost incurred by the current owner in acquiring the asset. 42 C.F.R. §413.134(b)(1). The annual depreciation is based on the historical cost and is prorated over the asset's estimated useful life in accordance with an acceptable depreciation method. 42 C.F.R. §413.134(a)(3).

[1] Transcript, pp. 5-6.

The calculated annual depreciation is only an estimate of the decline in value of the asset in the fiscal year. The actual decline in the value of the asset may differ considerably from the annual depreciation. As a result, the un-depreciated cost of the asset (i.e., the historical cost minus the accumulated depreciation to date) may differ from the asset's fair market value. If an asset is sold by the provider for less than its un-depreciated basis, there is a loss on disposal. In that case, the asset's actual decline in value is more than the estimated amounts previously claimed, and so the Program would reimburse the provider for the loss. Conversly, if an asset is sold for more than its un-depreciated value, there is a gain on disposal and the provider would reimburse the Program for the excess depreciation previously claimed. 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. The purchase price is allocated to all the assets sold regardless of whether they are depreciable or non-depreciable.

The regulation providing for the recognition of gains and losses was originally implemented to address 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 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, when a statutory merger is between related parties, the assets are not revalued and no gain or loss is recognized. 42 C.F.R. §413.134(1)(2).

The regulation governing gains and losses for statutory mergers (42 C.F.R. § 413.134(l)) provided:

> (2) Statutory merger. A statutory merger is a combination of two or more corporations under the corporation laws of the State, with one of the corporations surviving. The surviving corporation acquires the assets and liabilities of the merged corporation(s) by operation of State law. The effect of a statutory merger upon 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….

Paragraph (f) of 42 C.F.R. § 413.134 addresses gains and losses on disposal of assets. At the time of the merger, it stated:

> (f) Gains and losses on disposal of assets.--(1) General. Depreciable assets may be disposed of through sale, scrapping, trade-in, exchange, demolition, abandonment, condemnation, fire, theft, or other casualty. If disposal of a depreciable asset results in a gain or loss, an adjustment is necessary in the provider's allowable cost. The amount of a gain included in the determination of allowable cost is limited to the amount of depreciation previously included in Medicare allowable costs. The amount of a loss to be included is limited to the un-depreciated basis of the asset permitted under the program….

The Intermediary Manual states that a gain or loss is recognized when a provider is merged into another corporation that was unrelated to the provider prior to the merger. Part A Intermediary Manual, Part 4 Chapter V1 (CMS Pub. 13-4) §4502.6 provided:

> Statutory merger. 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….

Section 4404 of the Balanced Budget Act of 1997, passed in August of 1997, eliminated the statutory requirement that Medicare receive or pay its share of any gain or loss when there is a change of ownership of a hospital. Congress expressly provided that this alteration in the law applied only to changes of ownership that took place on or after December 1, 1997. See also 42 C.F.R. § 413.134(f).

In May of 2000, CMS issued CMS Pub. 15-1, §104.24, which provides:

> 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.

On October 19, 2000, CMS issued a Program Memorandum (Transmittal No. A-00-76) ("Program Memorandum or PM") which indicated that "special considerations" apply to mergers between non-profit corporations as opposed to for-profit corporations. The PM stated :

> Special Considerations Applicable to Transactions Involving Non-profit Organizations
>
> Non-profit organizations differ in significant ways from for-profit organizations. Non-profits typically do not have equity interests (i.e., shareholders, partners), exist for reasons other than to provide goods and services for a profit and may obtain significant resources from donors who do not expect to receive monetary payment of, or return on, the resources they provide. These differences, among others, cause non-profit organizations to associate or affiliate through mergers or consolidations for reasons that may differ from the traditional for-profit merger or consolidation. Because the regulations at 42 CFR §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.

Stating that it was a clarification, the Program Memorandum announced that Medicare would apply the "related party" test to the situation existing after the merger and would impose "*bona fide* sale" requirements on mergers and consolidations between non-profit hospitals.

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Hermann Hospital (Provider) was a 907-bed tertiary care teaching hospital located in Houston, Texas. Memorial Hospital System (MHS) was a Texas not-for-profit corporation that owned and operated six acute care hospitals in the greater Houston area. On November 4, 1997, the Provider consummated a statutory merger with MHS. MHS, as the surviving legal entity, changed its corporate name to Memorial Hermann Hospital System (MHHS) and changed the Provider's name to Memorial Hermann Hospital. MHHS continued as the hospital operating company for the Provider and its other hospitals. The Attorney General of the State of Texas issued a Certificate of Merger certifying to the Provider's statutory merger into MHHS. In accordance with the Provider Reimbursement Manual, Part I (CMS Pub.15-1), §2414.2(A), the Provider filed a terminating cost report for the period ending November 3, 1997, and claimed a loss on the depreciable assets in connection with the merger.

Trailblazer Health Enterprises (Intermediary) audited the November 3,1997 termination cost report and found that there was no common ownership or control between the Provider and MHS prior to the merger.[2] The Intermediary also found that while the transaction was a statutory merger, "[c]ontrol of Hermann Hospital…effectively did not change as a result of the merger" and that the terms of the merger agreement did not indicate the transaction satisfied "arm's length" considerations for a "bona fide sale".[3] On July 20, 2004, the Intermediary issued an NPR disallowing the Provider's loss.[4]

[2] Exhibit P-10 at 1.
[3] Id.
[4] Exhibits P-1 (audit adjustment 50); P-10 at 17.

On January 10, 2005, the Provider filed a request for hearing with the Board contesting the Intermediary's disallowance of the loss. The Provider's filing met the jurisdictional requirements of 42 C.F.R. §§405.1835-405.1841. The Provider was represented by Dan M. Petersen, Esquire, of Fulbright and Jaworski, L.L.P. The Intermediary was represented by Bernard M. Talbert, Esquire, of Blue Cross Blue Shield Association.

PROVIDER'S CONTENTIONS:

The Provider contends that Medicare has traditionally recognized gains or losses when a transaction involving a change of ownership ("CHOW") occurred[5] and that under the law in effect on the date of the merger, Hermann was entitled to claim a loss on merger on its 1997 terminating cost report. There was no "*bona fide* sale" requirement applicable to statutory mergers at that time and the test was whether the merging corporations were unrelated prior to the merger, not afterwards.

The Provider argues that under the clear terms of 42 C.F.R. § 413.134(l) and CMS Pub. 13-4 §4502.6, a statutory merger between unrelated parties triggers the gain and loss provisions of 42 C.F.R. § 413.134(f). Futhermore, the terms of § 4404 of the Balanced Budget Act of 1997, eliminating recognition of gains and losses on hospital changes of ownership, were not effective until December 1, 1997. The Provider further contends that Congressional intent was clear that this change in the law was to be applied prospectively only. The merger of Hermann into MHS occurred prior to December 1, 1997 and was a statutory merger between parties that were unrelated prior to the transaction. There is no dispute that these two not-for-profit entities were unrelated prior to the merger or that the surviving corporation (renamed MHHS) was operated as a provider.[6] The Provider argues, therefore, that it is entitled under the law in effect at the time of the transaction to be reimbursed for Medicare's pro rata share of the loss.

The Provider also argues that the provisions of the PM (CMS Pub. 60A Transmittal No. A-00-76) are substantive changes to existing provisions that are improperly applied retroactively. The Program Memorandum states:

> The fact that the parties are unrelated before the transaction does not bar a related organizations finding as a result of the transaction….Moreover, whether the constituent corporations in a merger or consolidation are or are not related is irrelevant….

The Provider argues that these assertions directly contradict Medicare regulations and policies. CMS Pub. 13-4 §4502.6 required a gain or loss to be computed where the two corporations "were unrelated parties prior to the transactions." Further, CMS's regulation states that the gain and loss rules in 42 C.F.R. § 413.134(f) are triggered when the "statutory merger is between two or more corporations that are unrelated."[7] The Provider asserts that whether "the constituent corporations in a merger or consolidation

[5] See 42 C.F.R. §413.134(1).
[6] Exhibit P-10 at 1; FI Pos. Paper at 10.
[7] 42 C.F.R. § 413.134(l).

are or are not related" is precisely the test that was stated by Medicare regulations and manuals when the merger took place.

The Provider also argues that the only authorities cited by the Program Memorandum to support these new "post-merger" relatedness principles for non-profits are CMS Pub. 15-1 §1011.4 and CMS Ruling 80-4. The Provider contends that those authorities provide no support for the new rules announced in the Program Memorandum. CMS Pub. 15-1 §1011.4 relates to situations where two corporations are already related by common ownership or control, and does not address the situation where the corporations were unrelated prior to the sale. CMS Ruling 80-4 dealt with the related party principle in the case of an ongoing contract for services, it did not involve a change of ownership, and was decided years before CMS published, in 1986, the CHOW provisions in the Intermediary Manual.

The Provider also contends that the *bona fide* sale provisions in the Program Memorandum impose new requirements that were not contained in previous regulations or guidance. The Provider further contends that the Program Memorandum cites neither facts nor authority for distinguishing non-profit corporations from for-profit corporations, and that the statutes, regulations and manual provisions existent at the time of the merger drew no such distinction.

Moreover, the Program Memorandum also cites no authority existing in 1997 for its new rule that the "combining" of assets and liabilities of non-profit providers, especially if the liabilities are less than the asset values, makes the transaction a non-*bona fide* sale. CMS regulations and manual provisions dealing with changes of ownership in 1997 and before did not contain a requirement that the assumed liabilities had to equal or nearly equal the assets before a loss would be recognized. CMS stated rather:

> [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 non-stock, nonprofit corporations in which the surviving or new corporation assumes debt of the merged or consolidated corporations, the basis of the assets in the hands of the surviving or new corporation would be [as specified in 42 U.S.C. § 1395x(v)(1)(O)]…. In addition, 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). For purposes of calculating the gain or loss, the amount of the assumed debt would be used as the amount received for the assets….[8]

[8] Exhibit P-12 (Goeller Letter) .

The Provider asserts that the Program Memorandum retroactively changes the rules for transactions that occurred before the cut-off date established by Congress. This action is contrary to the clear Congressional intent in passing § 4404 of the BBA as applied to changes of ownership that occurred after December 1, 1997. The Provider further argues that the Program Memorandum makes "substantive" changes in the payment rules, since it disallows losses that would otherwise have been routinely allowed. As such, it is in violation of 42 U.S.C. § 1395hh which requires that CMS proceed by notice-and-comment rulemaking in the Federal Register and is also contrary to well established Supreme Court precedent that holds that CMS may not engage in retroactive rulemaking.[9]

The Provider also notes that, prior to the Program Memorandum, the PRRB, the Administrator, and the courts routinely recognized gains and losses resulting from transactions involving non-profit providers without distinguishing them from transactions involving for-profit providers, or applying the new "post-merger relatedness" or "*bona fide* sale" tests.[10] The Provider also cites PRRB decisions to show that the Board has repeatedly rejected the position taken by the Program Memorandum on both the *bona fide* sale requirement and the related party principle.[11]

Although the Provider contends that the "*bona fide* sale" provisions do not apply to this merger, it nevertheless asserts that this was a *bona fide* transaction, after arm's length negotiation, by informed parties acting in their own self-interest, for reasonable consideration. The Provider argues that it had actively searched for merger or affiliation partners and held discussions with The Methodist Hospital, St. Luke's Episcopal Hospital, and the Sisters of Charity of the Incarnate Word. [12] The Provider contends that the evidence shows that due diligence was exercised, negotiations extended over a year, each party was represented by legal counsel from outside law firms, and discussions were often contentious and adversarial in nature. [13] The Provider also argues that the evidence demonstrated that there was a negotiation over price. [14]

The Provider also contends that the specific terms of the merger were officially approved by the state Attorney General, who has supervisory authority over charitable trusts, and by a court proceeding instituted especially for that purpose. The Provider argues that this approval demonstrates that the terms of the transaction were fair and reasonable. The

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[9] Bowen v. Georgetown University Hospital, 488 U.S. 204 (1988).

[10] See St. Mark's Charities Liquidating Trust v. Shalala, 952 F. Supp. 1488 (D. Utah, 1997), aff'd, 141 F.3d 978 (10th Cir. 1998); Dakota Midland Hospital v. Blue Cross and Blue Shield Association/Blue Cross and Blue Shield of Iowa, PRRB Dec. No. 1997-D72 (CCH) ¶ 45,464; St. Luke Hospital v. Aetna Life Insurance Company, PRRB Dec. No. 1995-D17 (CCH) ¶ 43,038; St. Luke Hospital v. Aetna Life Insurance Company, HCFA Administrator Decision, March 8, 1995 (CCH) ¶ 43,261; Buckingham Valley Center v. Aetna Life and Casualty Company, PRRB Dec. No. 1990-D13 (CCH) ¶ 38,369.

[11] New England Deaconess Hospital v. BlueCross BlueShield Association/National Government Services, PRRB Dec. No. 2009-D24 (CCH) ¶ 82,326; Whidden Memorial Hospital v. BlueCross BlueShield Association, PRRB Dec. No. 2009-D34 (CCH) ¶ 82,401; St. Francis Regional Medical Center v. Blue Cross Blue Shield Association/Blue Cross Blue Shield of Kansas, PRRB Dec. No. 2009-D29 (CCH) ¶ 82,333.

[12] Tr. 1. 82-83, 213.

[13] Tr. 1. 89-90, 95, 102, 135, 174-75, 203, 256-57.

[14] Tr. 1. 162.

Provider argues further that the Court made specific findings that the merger was consistent with the Hermann trustees' fiduciary duties, and was needed to ensure the future viability of Hermann Hospital.[15] The Provider argues that the Court's finding that the merger was consistent with the trustees' fiduciary duties means that the price and terms were necessarily not less than fair market value.

The Provider further contends that the consideration was necessarily reasonable because it resulted from arm's length bargaining by well-informed parties acting in their own self-interest.[16]

INTERMEDIARY'S CONTENTIONS

The Intermediary argues that PM A-00-76 recognized that many non-profit mergers and consolidations involve the continuation, in whole or in part, of the former governing board and/or management team members. The PM requires that consideration be given to whether the composition of the new board of directors or other governing body or management team includes significant representation from the previous board or management team. If so, the Intermediary argues that no real change of ownership has occurred and, no gain or loss may be recognized as a result of the transaction. The Intermediary contends that the PM further recognized that certain relationships formed as a result of the consolidation of two entities constitute a related party transaction for which a loss on the disposal of assets may not be recognized. The Intermediary argues that the relationship test should include the relationship between the constituent hospitals and the consolidating entity. PM A-00-76 states:

> …whether the constituent corporations in a merger or consolidation are or are not related is irrelevant; rather, the focus of the inquiry should be whether significant ownership or control exists between a corporation that transfers assets and the corporation that receives them.

The Intermediary contends that the CMS Pub. 15-1, Chapter 10 makes clear that determinations of common control are subjective and that each situation stands on its own merits and unique facts. Further, a finding of common control does not require ownership of 50 per cent or more. Rather, the mere potential to control is sufficient. The Intermediary contends that many non-profit hospital mergers and consolidations are driven only by the interests of the community at large, which does not always require engaging in a *bona fide* sale or seeking the fair market value of assets. Rather the assets are simply combined on the merged/consolidated entity's books. The merged/ consolidated entity may or may not record a gain or loss resulting from such a transaction for financial reporting purposes.

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[15] Exhibit P-9.

[16] The Provider cites Jeanes Hospital v. Wisconsin Physicians Service, PRRB Dec. No. 2009-D23; see also Jeanes Hospital v. Leavitt, 453 F. Supp. 2d 888, 903 (E.D. Pa. 2006).

Regardless, the Intermediary contends that no gain or loss may be recognized for Medicare payment purposes unless the transfer of the assets resulted from a *bona fide* sale as defined in the CMS Pub. 15-1 §104.24. In addition, the PM states that per the regulation at 42 C.F.R. §413.134(k), a gain or a loss resulting from the combining of multiple entities' assets and liabilities is not permitted unless a *bona fide* sale occurred. A *bona fide* sale requires an arm's length business 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.

The Intermediary also argues that the PM requires an examination of all parties to the transaction, both before and after its completion and notes the PM's requirement is consistent with earlier CMS Administrator decisions.[17] The Intermediary asserts that the merger was between related parties as defined in 42 C.F.R. §413.17 and cites the CMS Administrator's decision in Iowa Lutheran Hospital[18] and UPMC - St. Margaret Hospital[19] as support of that principle to this case. Further, the merger failed to meet the *bona fide* sale criteria outlined in PM A-00-76. There is nothing in the record to support the Provider's assertion that the value of the assets of the Provider declined to zero when the facility continued in operation, albeit under a different name, without interruption.

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 that the Provider and MHHS were unrelated parties as that term is defined under the regulatory provisions of 42 C.F.R. §413.17 and 42 C.F.R §413.134. Accordingly, a revaluation of the assets and a recognition of any loss that may have been 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 agree that the transaction at issue was a statutory merger under Texas 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." It is undisputed that the Provider merged into Memorial Health Service (MHS) which then became known as Memorial Hermann Hospital System (MHHS). As the surviving corporation, MHHS acquired all of the assets and assumed all the liabilities associated with the operations of the Provider.

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[17] St. Clare's Hospital – Dover v. Blue Cross Blue Shield Association, CMS Administrator Decision (Review of PRRB Dec. No. 2004-D38), November 12, 2004.

[18] Iowa Lutheran Hospital v. Blue Cross Blue Shield Association, PRRB Dec. No. 2007-D1, Oct. 6, 2006 Medicare and Medicaid Guide (CCH) ¶81616, rev'd. by CMS Adm. Dec., December 8, 2006, Medicare and Medicaid Guide, (CCH) ¶81629.

[19] UPMC – St. Margaret Hospital v. Blue Cross Blue Shield Association – Veritus Medical Services, PRRB Dec. No. 2006-D23, May 26, 2006, Medicare and Medicaid Guide (CCH) ¶81529, rev'd. by CMS Adm. Dec., July 25, 2006, Medicare and Medicaid Guide (CCH) ¶81546.

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. . . .
>
> (ii) *Statutory merger between related parties.* If the statutory merger is between two or more related corporations (as specified in §413.17), no revaluation of assets is permitted for the assets acquired by the surviving corporation. . . .

Accordingly, the initial question to be decided by the Board is whether the subject merger was between related parties. While it is undisputed that the Provider and MHHS were unrelated prior to the merger, the Intermediary argues that the phrase "between related parties" requires that the relationships after the merger transaction be examined as well. The related party regulation at 42 C.F.R. §413.17 states, 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.
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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.
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> (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.

The Intermediary relies on subsection (3) that discusses control, particularly in light of two other policy statements interpreting these regulations. HCFA Ruling 80-4 provides that the applicability of the related organization rule is not necessarily determined by the absence of a relationship between the parties prior to their initial contracting, although these factors are to be considered. The applicability of the rule is determined also by considering the relationship between the parties according to the rights created by the

contract. Therefore, the Intermediary contends it is appropriate to evaluate the leadership of the post-merger organization for the purpose of determining control.

The Intermediary also argues that its position is supported by CMS Pub. 60A Transmittal No. A-00-76 (Oct. 19, 2000). It purports to be a clarification of the merger and consolidation regulation as it applies to non-profit entities. It requires the Intermediary to evaluate the composition of the governing boards or management team of pre and post merger organizations to determine relatedness. The Intermediary contends that because the Provider's governing body actively secured participation in the management of the new entity, the Provider was a related party to the surviving corporation.

The Board finds the plain language of the statutory merger regulation dispositive of the Intermediary's argument. The text at 42 C.F.R. §413.134(l)(2)(i), which states, "if the statutory merger is between two or more corporations that are unrelated . . ." is 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.

The Board's conclusion is further buttressed by the Secretary's interpretive guidelines published in CMS Pub. 13-4 §4502.6. It states, 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 further finds that HCFA Ruling 80-4 is inapplicable because it does not apply to the facts in this case. This Ruling requires consideration of the relationship between unrelated parties according to the new rights created by their contract. The Board finds the facts in this case show that this is a one-time transaction with one of the parties ceasing to exist. There is no continuing relationship thereafter. Since no continuing relationship remained, there is no related party relationship under HCFA Ruling 80-4.

The Board also finds that PM A-00-76, published long after the transaction at issue here, is not a clarification of policy but a change in interpretation. Evidence presented at the hearing, including testimony of experienced consultants and prior HCFA correspondence, shows that in prior interpretations, relatedness for a merger transaction was determined solely on relationships prior to the merger.[20]

Finally, the Board finds that even if the Provider had to prove it was unrelated after the merger, the Provider would nevertheless prevail. The Board finds that although the Provider's management sought influence over the new entity, these individuals did not have the ability to significantly influence or control the surviving corporation as required by 42 C.F.R. §413.17(b)(3).[21] Moreover, there also was no longer a "provider entity" to benefit from these individual members' actions. Once the merger was completed, any trustee or board member who crossed over to the surviving corporation would be duty

[20] See, 1987 Goeller letter, Exhibit P-12; Booth letter, Provider exhibit P-11.
[21] Transcript 1, pp. 112-126.

bound to act in the best interest of the surviving corporation. Further, the undisputed evidence indicates the policies and operations were controlled by the surviving corporation. Likewise, the Provider's managerial and clinical staff who continued to work for the surviving corporation had minimal influence in comparison to the individuals who were associated with the surviving corporation both before and after the merger.[22]

The Intermediary argues that even if the parties were unrelated, the transaction did not meet the requirement of a *bona fide* sale. The Intermediary again relies on CMS Pub. 60A Transmittal No. A-00-76 (Oct. 19, 2000) to evaluate whether a *bona fide* sale has occurred with respect to a merger between non-profit entities. This 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." In the "special considerations applicable to transactions involving non-profit organizations" section, the PM goes on to state that "because 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."

The Board recognizes that the Courts have determined that the PM is a reasonable reading of the regulations and is entitled to deference.[23] The PM directs the Intermediary to determine whether a "*bona fide* sale" occurred, as evidenced by whether the seller obtained "reasonable compensation" for the depreciable assets. A *bona fide* sale is described as: an arms 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."[24] The PM's definition of *bona fide* equates "reasonable compensation" with the fair market value of assets. Application of the PM requires an analysis of fair market value (FMV) of the individual depreciable assets involved in the merger. However, the record provides no direct evidence of the FMV of the assets. There was no independent appraisal at the time of the transaction nor did the Board find other evidence of FMV within the record. The net book value was available through the facility's financial statements for use as a starting point. [25]A number of factors operated to increase the value of the facility. The facility's location, its continued revenue generation and its patient utilization all combined to increase the value of the assets. Conversely, the age of the facility's buildings, its unique charity care obligations and the restrictions in its charter all operated to reduce the value. The Board can find no way to estimate the dollar effect of the countervailing conditions and accordingly can find no way to arrive at an FMV for the facility.

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[22] Transcript1, pp. 275-279.

[23] Via Christi Regional Medical Center V. Leavitt, 509 F.3d 1259 (December 7, 2007); Robert F. Kennedy Medical Center v. Leavitt, 526 F.3d 557 (May 19, 2008); Albert Einstein Medical Center v. Sebelius, 565 F.3d #68(May 22, 2009): See also Exhibit I-9.

[24] As adopted, Transmittal No. 415 (May 2000).

[25] The financial statements show the value without any write-down.

The Board notes that the Provider used Accounting Principles Board (APB)[26] Opinion 16 as the basis for calculating the loss on depreciable assets.[27] The Opinion 16 assigns values on the basis of cost across the assets. This method is permissible under Generally Accepted Accounting Principles (GAAP) but does not satisfy the Medicare valuation requirements. The regulations at 42 C.F.R. §413.134(f)(2)(4) require that when more than one asset is sold for a lump sum, the gain or loss of each depreciable asset must be determined by allocating the lump sum sales price among all 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 Board observes that the regulatory concept of a depreciation adjustment would be unnecessary if the net book value based upon cost could be considered fair market value. On the other hand, the Board also notes that if the fair market value of depreciable assets declined to a level significantly below the net book value, under GAAP, an impairment of assets would have been recorded and the net book value of the assets written down. The record contains no evidence of such impairment being recorded. The Provider's witness stated that to the best of his knowledge, the assets were never written down. See Tr. l, pp. 294-295, 304. Therefore, it appears that the fair market value did not deviate materially from the net book value of the assets.

Given the totality of these circumstances, i.e. there was evidence indicating the depreciable assets increased in value in some respects but decreased in others, that the owner's treatment of the assets for financial reporting purposes indicates it did not perceive the fair market value to be materially less than the net book value, and the lack of any direct evidence as to the fair market value, the Board concludes the net book value is the best evidence of fair market value of the assets.

The evidence shows the depreciable assets had a net book value, which the Board finds to be the best evidence of fair market value, of $145,542. Under the Provider's calculation using APB-16, the consideration related to these assets was zero. As noted above, the Board does not agree with the applicability of APB 16, but the Provider's failure to furnish any evidence regarding valuation of the assets makes an allocation as required by the regulation impossible. It would require assigning a proportional amount of the consideration to all assets based on their fair market value. While the evidence was sparse regarding quantification of the place value of the depreciable assets, there was even less evidence regarding value of all other non-current assets transferred. However, we find reaching a specific valuation to be unnecessary. Even using the provider's proposed adjusted valuation of 68 million[28] rather than the net book value of $145,542

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[26] The Accounting Principles Board (APB) was created by the American Institute of Certified Public Accountants in 1959 and issued pronouncements on accounting principles until 1973, when it was replaced by the Financial Accounting Standards Board (FASB).

[27] Transcript 2, pp. 294-299.

[28] P X 59. Provider's consultant testified the 145K NBV of depreciable assets should be adjusted to deduct what the consultant asserted was excess capacity; resulting in a valuation of 68 million. See pp. 8 paragraph C through p. 17 paragraph F and attachments 4 and 6; Provider's post hearing brief p. 55.

would compel a finding of no *bona fide* sale because of the disparity between that figure and the provider's calculation of the consideration given (zero).

DECISION AND ORDER:

The transaction was a merger between unrelated parties and is therefore subject to a depreciation adjustment. However, an application of the *bona fide* sale principles found in Transmittal No. A-00-76 (Oct. 19, 2000) indicates a wide discrepancy between the consideration given for the assets and their fair market value; consequently, a loss cannot be recognized. The Intermediary's adjustment is affirmed.

BOARD MEMBERS PARTICIPATING:

Yvette C. Hayes
Keith E. Braganza, C.P.A.
John Gary Bowers, C.P.A.

FOR THE BOARD:

Yvette C. Hayes
Acting Chairperson

DATE: March 24, 2011