PROVIDER REIMBURSEMENT REVIEW BOARD
HEARING DECISION

2003-D3

PROVIDER – Kaleida Health 97
Ownership of Assets Group

Provider No. Various, See
Attached List of Providers in
the Group

vs.

INTERMEDIARY – Blue Cross and
Blue Shield Association/Empire Medicare
Services

DATE OF HEARING-
October 10, 2002

Cost Reporting Periods Ended-
Various, See Attached List of
Providers in the Group

CASE NO. 01-0710G

INDEX

ISSUES:

Were the Intermediary's adjustments to the Providers' cost reports for FYE 12/31/97 to eliminate the Providers' claimed losses on disposition of assets proper?

> Did the Intermediary err in determining that the Providers disposed of their assets on or after December 1, 1997?
>
> Alternatively, is the regulation that eliminates recognition of gain or loss on asset sales on or after December 1, 1997 invalid, so that the Providers are entitled to losses on disposition of their assets regardless of the date on which that disposition occurred?[1]

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Kaleida Health is the successor in interest to Buffalo General Hospital, The Children's Hospital of Buffalo, Millard Fillmore Hospitals, and DeGraff Memorial Hospital (the "Providers"). The Providers were not-for-profit tertiary care hospitals located in Erie and Niagara counties in New York State. As described below, the four Providers merged to form a single not-for-profit hospital system now known as Kaleida Health. The Providers filed cost reports for FYE 12/31/97 claiming losses on the disposition of their assets as of November 24, 1997.[2] Empire Medicare Services (the "Intermediary") issued notices of Program Reimbursement ("NPRs")[3] adjusting each Provider's cost report to eliminate the claim for loss on disposition of the Provider's assets. The Providers filed appeals to protest these NPRs[4] to the Provider Reimbursement Review Board ("Board"). The Providers filing meets the jurisdictional requirements of 42 C.F.R. §§ 405.1835-.1841. The Medicare reimbursement effect is approximately $31 million.

The Providers are represented by Ellen V. Weissman, Esquire, and Robert J. Lane, Esquire, of Hodgson Russ, LLP. The Intermediary was represented by Eileen Bradley, Esquire, of the Blue Cross and Blue Shield Association.

---

1 Both parties have agreed that the issue concerning the validity of a regulation cannot be decided by the Board. Section 1878 (d) of the Act allows the Board only to "affirm, modify, or reverse the fiscal intermediary…." Subsection (f)(1) recognizes that only the judiciary may decide questions of a regulation's validity, but the Board has the authority to determine that it cannot decide the question so that the provider can proceed to federal district court. Both parties agreed that neither would brief the question nor address it at any oral argument.

2 Providers' Exhibit 2.

3 Providers' Exhibit 3.

4 Providers' Exhibit 4.

Background Concerning the Merger of the Providers:

Prior to and during 1997, the Providers engaged in discussions and plans to merge into a single hospital system. The parties to the proposed merger (the "Merger Parties") were:

Buffalo General Health System ("BGH")
The Children's Hospital of Buffalo ("CHOB")
Children's and Women's Health, Inc. (the parent of CHOB)
Millard Fillmore Hospitals ("MFH")
Millard Fillmore Health System (the parent of MFH)
Chimilgen Corporation ("CMG" formed specifically to be the surviving entity; changed its name to Kaleida Health after the merger)

In June of 1997, the Merger Parties submitted their Plan of Merger to various government agencies for approval. On November 24, 1997, the Merger Parties conducted a closing in escrow and signed a Memorandum of Closing.[5] This Memorandum of Closing committed the parties to filing the Certificate of Merger and related documents as soon as all government approvals were obtained. The Memorandum of Closing did not contain any contingencies within the control of the parties. The necessary government approvals (including the issuance of a Certificate of Need by the New York State Department of Health) were obtained in March of 1998, and the Certificate of Merger was filed with the New York Secretary of State on March 31, 1998.

As an integral part of the merger, DeGraff Memorial Hospital merged into BGH immediately before BGH merged into CMG. The merger in escrow included DeGraff Memorial Hospital (see Memorandum of Closing, Annex to Attachment B, A(3)), and the Certificate of Merger of DeGraff Memorial Hospital's merger into BGH also was filed with the New York State Secretary of State on March 31, 1998.

Each NPR issued by the Intermediary for the Providers' 12/31/97 cost reports contained an adjustment that disallowed the loss on sale because the effective date of this change in ownership was recognized by Medicare as April 1, 1998, so the revisions to section 42 C.F.R. § 413.134 apply.[6]

Legal Background:

Prior to December 1, 1997, CMS recognized a gain or loss when a provider's assets were disposed of for a price different than their net book value ("NBV" - basis minus depreciation for years in use). An asset disposed of for less than NBV indicated that CMS had not allowed enough depreciation on the asset, and the provider was allowed to claim an adjustment on its cost report to reflect the loss. Similarly, an asset disposed of for more than NBV indicated

[5] Providers' Exhibit 1.

[6] Providers' Exhibit 5.

that CMS had previously allowed too much depreciation, and the provider was required to adjust its final cost report to reflect the excess amounts previously allowed as depreciation.

The Balanced Budget Act of 1997 (Pub. L. No. 105-33, § 4404, codified at 42 U.S.C. 1395x(v)(1)(O)) ("BBA 97") amended the Medicare statute to provide that the allowance for depreciation after a sale of assets would be based on the historical cost of the assets less depreciation (i.e., the depreciated book value of the assets). CMS then issued amended regulations stating that Medicare would no longer allow a selling provider to file a cost report restating its depreciation to reflect the loss on sale (or, in the case of a gain, to require recapture of the overstated depreciation), even if the market value of the assets is less (or greater) than the depreciated book value at the time of the disposition. The regulatory amendment applies to asset changes of ownership occurring on or after December 1, 1997.

Medicare Statutes and Regulations

Section 1861(v) of the Social Security Act ("SSA" or the "Act"), 42 U.S.C. § 1395x(v), provides that the reasonable cost of a provider's services will be determined in accordance with regulations.

SSA § 1861(v)(1)(O)(i), before it was amended by BBA 97, directed that the regulations provide for a depreciation allowance for assets that change ownership, based on a valuation of the asset after its ownership that equals the lesser of the allowable acquisition cost of the asset to the owner of record as of July 18, 1984 (or the first owner of record after that date) or the acquisition cost of the asset to the new owner.

SSA § 1861(v)(1)(O)(i), following its amendment by BBA 97, directs that the regulations provide for a depreciation allowance for assets that change ownership, based on a valuation of the asset after its ownership changes that equals the historical cost of the asset, less depreciation allowed, to the owner of record as of August 5, 1997 (or the first owner of record after that date).

Regulations at 42 C.F.R. § 413.134(f), before it was amended on January 9, 1998, provided that an adjustment was necessary in a provider's allowable cost if disposition of a depreciable asset resulted in a gain or loss.

Regulation § 413.134(f), as amended by 63 Fed. Reg. 1382, Jan. 9, 1998, provides that an adjustment is necessary in a provider's allowable cost for gains or losses from the sale or scrapping of a depreciable asset before December 1, 1997, but that no gain or loss is recognized on the sale or scrapping of an asset on or after December 1, 1997.

Summary of New York Statutory and Common Law.

Section 905 of the New York Not for-Profit Corporation Law states:

> (a) Upon the filing of the certificate of merger and consolidation by the Department of State or on such date subsequent thereto, not to exceed thirty days, as shall be set forth in such certificate, the merger or consolidation shall be effected.
>
> (b) When such merger or consolidation has been effected:
>
> (1) Such surviving or consolidated corporation shall thereafter, consistent with its certificate of incorporation as altered or established by the merger or consolidation, possess all rights, powers and purposes of each of the constituent corporations.
>
> (2) All property real and personal, including causes of action, and every other asset of each of the constituent corporations shall vest in such surviving or consolidated corporation without further act or deed . . .
>
> (3) The surviving or consolidated corporation shall assume and be liable for all the liabilities, obligations and penalties of each of the constituent corporations.

(emphasis added).

Section 56 of Chapter 82 of New York State Chapter Laws of 2002 (Exhibit P-6), effective August 1, 1997, states:

> Notwithstanding any other provision of law, rules or regulations, the Memorandum of Closing entered into by health care providers located in Erie and Niagara counties dated November 24, 1997, which consummated an Agreement and Plan of Merger dated as of August 1, 1997, effected a change of ownership of assets of these providers as of November 24, 1997 (emphasis added).

New York State follows the common law doctrine of equitable conversion, under which the purchaser of real property becomes the equitable owner of the property at the time a binding agreement is entered into, and the seller retains legal title to the property until closing solely as security for payment of the purchase price.[7] Under New York law, equitable conversion is applied when an agreement is enforceable.[8] An agreement is enforceable in New York if it is reasonably certain in its material terms.[9]

---

[7] Providers' Response Brief at 3.

[8] Id.

[9] Id.

To summarize the conflict briefly, the Provider maintains that a Memorandum of Closing signed by all four Providers on November 24, 1997, constituted an effective disposition of depreciable assets and that they should benefit from the regulatory provision that was in effect before December 1, 1997. The Intermediary views the transaction as a statutory merger that was not complete under state corporation law until the filing of the certificate of merger in 1998. Since this did not occur until after December 1, 1997, the Providers should not benefit from the regulatory provision that was in effect before December 1, 1997.

PROVIDER'S CONTENTIONS:

The Providers contend that they disposed of their assets on November 24, 1997, the date on which the Memorandum of Closing was executed, and that their losses are allowable under 42 C.F.R. § 413.134(f). They argue that applicable federal law does not provide any guidance for determining when a sale or other disposition of assets has occurred, and that Medicare looks to state law to resolve such questions. The Providers contend that the date of the asset disposition should be determined under New York law.

The Providers contend that the loss on sale rules apply to the disposal of assets and are not limited to changes in ownership of providers. The Providers contend that they disposed of their depreciable assets on November 24, 1997 with the Memorandum of Closing. The Providers indicate that the Intermediary disallowed their loss-on-sale claims because the Centers for Medicare and Medicaid Services ("CMS" formerly called the Health Care Financing Administration ("HCFA")) had recognized the change in ownership of the Providers for purposes of Medicare certification as occurring on April 1, 1998 (i.e., after December 1, 1997). The Providers assert that the Intermediary has confused a change in ownership of the provider with a change in ownership of assets.

The Providers point out that the regulation at 42 C.F.R. § 413.134(f) deals with the disposition of assets through sale, scrapping, trade-in, exchange, demolition, abandonment, condemnation, fire, theft or other casualty. As amended, it states: "[i]f disposition of a depreciable asset, including the sale or scrapping of an asset before December 1, 1997, results in a gain or loss, an adjustment is necessary in the provider's allowable cost. (No gain or loss is recognized on either the sale or the scrapping of an asset that occurs on or after December 1, 1997.)" The pertinent terms in the regulation are "disposition" and "sale" of "assets;" there is no reference to a change of ownership of a provider.

The Providers assert that the Intermediary has limited its attention to whether there has been a "change in ownership" of the Providers and has ignored whether there was a disposition of assets on or before December 1, 1997. The Providers contend that they need not show that there was a change in the ownership to prevail in this case. Although a change in ownership, as defined by Medicare, necessarily entails a disposition of tangible, patient-related assets, there can easily be a disposition of assets without there being a "change in ownership" of a provider.

The Providers note that neither SSA § 1861(v)(1)(O) nor 42 C.F.R. § 413.134(f) provides any guidance for determining when a sale or other disposition of assets has occurred. Where federal law is silent on an issue such as the effective date of a sale, Medicare looks to state law to resolve the question. For example, the CMS Deputy Administrator affirmed a Board decision which relied on state law to determine the date on which a sale occurred in connection with a provider's claimed loss on the sale. According to the Deputy Administrator, it was proper for the Board to apply state law, since there was no Medicare provision for determining when a sale had occurred. Fort Pierce Memorial Hospital v. Blue Cross and Blue Shield Association/Blue Cross of Florida, PRRB Dec. No. 83-D154, Sept. 28, 1983, Medicare and Medicaid Guide (CCH) ¶ 33,582, aff'd, CMS Adm'r Dec., Nov. 22, 1983, Medicare and Medicaid Guide (CCH) ¶ 33,603 ("Fort Pierce"). The Board determined that the application of state law was appropriate and relevant to resolve issues as to whether an agreement was enforceable, since federal law did not address the issue. Central Hospital v. Blue Cross and Blue Shield Association/Blue Cross and Blue Shield of Massachusetts, Dec. No. 97-D18, D-19, D-20, December 30, 1996, Medicare and Medicaid Guide (CCH) ¶ 45,015, rev'd, CMS Adm'r Dec., Nov. 22, 1983, Medicare and Medicaid Guide (CCH) ¶ 45,179 (" Central Hospital"). In a similar case, the Eighth Circuit upheld the Board's use of state law. AMISUB Inc. v. Shalala, 12 F.3d 840 (1994). CMS's own regulations and manuals look to state law to determine certain issues (e.g., whether agreements create an enforceable obligation for purposes of CMS's capital Prospective Payment System ("PPS") rules; See 56 Fed. Reg. 43358 (Aug. 30, 1991), and Provider Reimbursement Manual (CMS Pub. 15-1) § 2807.3).

The Intermediary contends that the date on which the Providers' Certificate of Merger was filed is controlling for purposes of determining when ownership of their assets changed. The Provider disagrees and points out that Medicare statutes, New York State common law and statutory law, and the Fort Pierce case previously decided by the Board and affirmed by the CMS Deputy Administrator all support the Providers' position that the transfer of assets occurred on Nov, 24, 1997, the date on which the Providers executed the Memorandum of Closing prior to December 1, 1997. In addition, there is case authority in analogous circumstances where reimbursement consequences have ensued as soon as the first step of a multi-step transaction has been taken. Therefore, the Intermediary erred in disallowing the loss on sale.

The Providers assert that New York law is critical in determining the date on which the Providers disposed of their depreciable assets. CMS precedent applies the state law doctrine of equitable conversion to determine the date on which a disposition of assets occurs for purposes of its loss-on-sale provisions.

In the Fort Pierce case, the Board applied, and the CMS Deputy Administrator upheld, a state's common law doctrine of equitable conversion to determine the date on which a provider disposed of its depreciable assets for purposes of the loss-on-sale rules. The

Provider notes that the Intermediary claims the Fort Pierce case has "a unique set of facts" and, therefore, apparently should not be applied to the Providers' case.[10]

The facts in Fort Pierce are as follows:

- The regulation at issue in the case was the regulation dealing with loss on the disposition of depreciable assets (42 C.F.R. § 405.415(f), which was subsequently renumbered as § 413.134(f)).
- The hospital executed an enforceable purchase contract with the transferee on December 29, 1978, four days before the hospital's ability to claim a loss-on-sale would have expired.
- The sale closed on December 28, 1979, one year after the contract was signed, when the deed was delivered and the purchase price was paid.
- The delay in closing the transaction resulted from the need to obtain government (HUD and Hill-Burton) approvals to the transaction.
- The Board applied the state law doctrine of equitable conversion, holding that the sale of assets occurred on December 29, 1978, the date on which the parties entered into an enforceable contract where the only contingencies were governmental approvals not within the control of the parties.
- The CMS Deputy Administrator upheld the Board's decision. The Deputy Administrator stated that "the key point as to whether the doctrine [of equitable conversion] is applicable seems to be whether the contract was enforceable … by the parties to the contract."

The Providers argue that the facts in the Providers' case are extremely similar to the Fort Pierce case. The providers in both cases needed to dispose of their assets by a specific date in order to be eligible to claim a loss on the disposition. The only reason that the providers were unable to close on the disposition was due to the long time-frame involved in obtaining necessary government approvals. In both cases, the providers entered into enforceable written contracts for the transfer of their assets. In Fort Pierce, transfer of legal title to the assets occurred 12 months after the contract was executed; in Kaleida Health's case, transfer of legal title occurred only 4 months after the contract was executed. The exact same regulation is at issue in both cases, and both states (New York and Florida) apply the same common law doctrine of equitable conversion.[11]

---

[10] Intermediary's Paper at 19.

[11] Providers' Response Brief at 7.

The Intermediary contends that "[a] better reading of the agency's regard for the doctrine [of equitable conversion] is reflected in the Administrator's decision in Central Hospital (Feb. 13, 1997)." The Provider avers that Central Hospital, however, does not deal with the doctrine of equitable conversion at all. Moreover, its facts are very different from those of the Providers' situation. The facts in Central Hospital are:

- The hospital and a prospective buyer executed a letter agreement on April 27, 1984, in which the buyer undertook to purchase, at its option, either the stock or the assets of the hospital. The parties agreed that the transaction would be set forth more fully in a Stock Purchase or Asset Acquisition Agreement.

- At the time they executed this letter agreement, neither party had initiated the process for receiving a Determination of Need from the state health authority for the hospital that would result from the purchase transaction.

- The hospital and the buyer executed an Asset Acquisition Agreement on March 15, 1985, nearly a year after they signed the letter agreement.

- The Asset Acquisition Agreement changed material terms of the letter agreement, including the purchase price, and added other terms and conditions.

- The parties amended the Asset Acquisition Agreement on March 15, 1986, to increase the purchase price and change the closing date.

- The parties amended the Asset Acquisition Agreement a second time on December 1, 1986, to increase the purchase price and to substitute a new purchaser.

- The asset sale closed on March 15, 1987.

- The Board ruled that the letter agreement was an enforceable agreement, and the date of that contract governed the hospital's right to a loss-on-sale claim.

- The CMS Administrator overturned the Board and determined that the sale was governed by the Asset Acquisition Agreement and its amendments, which made substantial changes in material terms of the original agreement, and the date of the Asset Acquisition Agreement governed the hospital's right to a loss-on-sale claim.

The Intermediary cites Central Hospital for the proposition that "when a contract among or between parties has so many unsatisfied critical contingencies that the parties themselves established, it has defeated enforcement by its own terms."[12] Contrary to the Intermediary's assertion, the Providers contend however, that the CMS Administrator overturned the Board

[12] Intermediary's Paper at 19.

in Central Hospital not because of "many unsatisfied critical contingencies," but because the CMS Administrator found that the sale was governed by a later agreement, which was not in existence when the loss-on-sale date expired, that made substantial changes to material terms of the sale.

In the Providers' case, by contrast, the Memorandum of Closing was the final agreement among the parties. It was executed before December 1, 1997, and there were no changes in its terms after it was executed. At the closing-in-escrow on November 24, 1997, all parties to the merger executed the Memorandum of Closing and the Certificate of Merger, and turned over to the escrow agent more than 60 other documents -- each of which was final and executed by the proper parties -- relating to the transaction.[13] The executed Certificate of Merger and the other executed documents were held by the escrow agent until the remaining governmental and financial approvals were obtained, at which time the escrow agent filed the Certificate with the New York State Secretary of State.

In both Fort Pierce and Central Hospital, the Board and the CMS Administrator held that state law was determinative as to the effective date of asset transfers for purposes of Medicare loss-on-sale regulations. The Provider asserts that the Fort Pierce determination is directly on point with the Providers' case, both in its facts and in the regulation at issue. The Board should follow Fort Pierce and determine that the Providers disposed of their depreciable assets on November 24, 1997.

The Fort Pierce decision is solidly in the mainstream of interpretation of the Medicare principles of reimbursement where equitable title is what is viewed as important for Medicare payment purposes. This is apparent from the Medicare treatment of revenue bonds and self-insurance trusts. In all such instances, "legal" title to funds is held by a trustee, but the equitable title is held by the provider and that is what is relevant for Medicare payment purposes.

Thus, in the case of revenue bond transactions, advanced refunding of debt and self-insurance trusts, where a provider transfers legal title to assets to a trustee and equitable title is held by the provider, Medicare treats the provider as the entity entitled to claim costs and required to offset revenues earned on assets held by the trustee. Albany Medical Center Hospital v. Blue Cross Association/Blue Cross of Northeastern New York, PRRB Dec. No. 78-D43, June 16, 1978, Medicare and Medicaid Guide (CCH) ¶ 29,215, aff'd, CMS Adm'r, August 15, 1978, Medicare and Medicaid Guide (CCH) ¶ 29,242 (revenue bond transaction); Provider Reimbursement Manual (CMS Pub. 15-1) § 233.3.D (advanced refunding of debt) and §§ 2162.3 and 2162.7 (self-insurance funds).

The Intermediary cites to various conditions described in the Agreement and Plan of Merger, which was executed on August 1, 1997.[14] The Providers note that agreement, however, was

---

[13] Attachment B to the Memorandum of Closing, Providers' Exhibit 1.

[14] Intermediary's Paper at 12-15.

modified and superceded by the November 24, 1997 Memorandum of Closing. In Section 3 of the Memorandum of Closing, each party agreed that, except for specified Governmental Approvals and Financial Approvals, all of the conditions to its obligations to proceed with the Merger had been satisfied. As of November 24, 1997, all of the conditions described in Sections 2.6(a), 2.6(b), 2.6(d), 2.6(e), 2.6(g) and 2.6(h) of the Agreement and Plan of Merger had been satisfied.

The only remaining conditions to the merger were those outside of the control of the parties. The existence of such conditions does not prevent the Memorandum of Closing from being an enforceable agreement. The agreement in Fort Pierce contained similar conditions, which remained outstanding much longer than those in the Providers' case, and the Board still found that the agreement was enforceable and effected a transfer of equitable title to the provider's assets.

Section 4.3 of the Memorandum of Closing states that each constituent corporation is legally bound to complete the merger upon receipt of the Governmental and Financing Approvals. Thus, the Memorandum of Closing was enforceable by the parties. Since "the key point as to whether the doctrine [of equitable conversion] is applicable seems to be whether the contract was enforceable…by the parties to the contract" (CMS Deputy Administrator in Fort Pierce), the doctrine is applicable in the Providers' case and the Board should apply it and determine that, for loss-on-sale purposes, the Providers disposed of their depreciable assets on November 24, 1997.

The New York State legislature enacted Section 56 of Chapter 82 of New York State Chapter Laws of 2002, which provides that ownership of the Providers' assets changed on November 24, 1997.[15] Contrary to the Intermediary's statement that the statute attempted to put the Providers in a position that was the opposite of where they stood as a matter of state law, the statute confirms the conclusion under New York common law that equitable title to the Providers' assets was transferred on November 24, 1997.

It is noteworthy that when BBA 97 was enacted on August 5, 1997, Congress made Section 4404 effective approximately three months after the date on which the statute was signed into law.[16] This is significant. It means that Congress intended to allow transactions that were in process to be completed before the effective date. Otherwise, Congress would have made this provision effective immediately, as it did for many other provisions.

---

15 The Providers note that the legislative memo attached as Intermediary Exhibit 11 of the Intermediary's Paper is unrelated to the statute confirming the date on which asset ownership changed.

16 The effective date provision, set forth in BBA 97 § 4404(b), states that: "[t]he amendments made by subsection (a) apply to changes of ownership that occur after the third month beginning after the date of enactment of this section."

The Providers are precisely the type of provider Congress meant to protect when it made the effective date of BBA 97 three months after the date it was enacted. The Providers had been planning their merger for almost a year and had relied on the existence of the loss-on-sale provision in existing statutes and regulations in determining whether the proposed merger would be financially feasible. Moreover, they had taken all steps within their control to consummate that merger and the transfer of assets before December 1, 1997.

It is virtually impossible to complete New York State's certificate of need ("CON") process in less than six months.[17] Change of ownership of a hospital requires review by the staff of the New York State Department of Health ("DOH"), the Project Review Committee of the State Hospital Review and Planning Council ("SHRPC"), the full SHRPC, the Establishment Committee of the Public Health Council, and then the full Public Health Council ("PHC"). NY Public Health Law § 2801-a. These bodies generally meet once every other month.

In addition, a hospital that provides services licensed by state agencies other than the Department of Health, such as substance abuse services licensed by the Office of Alcoholism and Substance Abuse Services ("OASAS") or mental health services licensed by the Office of Mental Health ("OMH"), also must file an application with each such agency seeking consent to proceed. NY Public Health Law § 2801(1) and NY Mental Hygiene Law §§ 1.03, 31.02.

Since the Providers were licensed to provide services by all three New York state agencies (DOH, OASAS, and OMH), they were required to file applications with each agency. As described below, the Providers filed each required CON application well before December 1, 1997. The DOH application was filed on June 23, 1997, and the OASAS and OMH applications were filed on August 19, 1997.

If New York State had been able to complete its regulatory approval processes within three months of the time that the Providers submitted their CON applications to DOH, OASAS and OMH, the Providers would not be here arguing before the Board. However, New York State has such a cumbersome regulatory process for approving hospital mergers, requiring review by multiple state agencies, that it could not complete the regulatory review process within three months. In enacting Section 56 of Chapter 82, the New York State legislature sought to address any perceived problem that its own lengthy state regulatory processes had created.[18]

---

[17] The Provider point out that the Medicare regulations on the capital prospective payment system explicitly recognized that some states such as New York State have a lengthy CON process. 42 C.F.R. § 412.302(c)(2); 56 Fed. Reg. 43358 (Aug. 30, 1991).

[18] The Providers note that the Intermediary expresses shock at the section of the statute that addresses Medicaid. The Providers state that, contrary to the Intermediary's assertion, this portion of the statute was included for two reasons: it was a simple way of assuaging potential concerns of legislators who are unfamiliar with the detailed workings of Medicaid reimbursement, and it satisfied the state legislature

The Providers assert that they had taken all steps within their control prior to December 1, 1997, and the transaction was substantially complete before Dec. 1, 1997. The Providers delineated and documented all of the steps they took to garner the approvals that they needed with regard to the antitrust filings, the New York State Department of Health filing, the New York State Office of Alcoholism and Substance Abuse filing, and the State office of Mental Health filing.[19]

The Providers point out that the Memorandum of Closing was executed on November 24, 1997, with the prior approval of the Directors and members, if any, of each party.[20] The parties conducted a closing in escrow on that date, at which they transmitted more than 60 fully executed documents to the custody of an escrow agent, to be held for immediate filing once the requisite governmental regulatory approvals had been obtained.

The Provider contends that the Board, the CMS Administrator and the courts have frequently invoked in a variety of contexts the principle that substance, rather than form, should govern Medicare payment.

The best known cases on this issue involve cases where there is a two-step transaction when an acquirer first purchases all of the outstanding stock of a hospital corporation and then subsequently liquidates or merges the assets of the purchased hospital corporation into the entity that purchased the stock. The agency's historic position had been to treat the first step of the transaction, the stock purchase, as not being a change in ownership since the same hospital corporation held legal and equitable title both before and after the transaction. The agency agreed that the second step of the transaction was a disposal/ acquisition of assets but said that there were no reimbursement consequences since it was a related party transaction. The courts unanimously rejected the agency's position. As the D.C. Circuit said:

> We rejected this artificial approach, holding it "arbitrary, erroneous, and irrational" not to treat the acquisition as a single, integrated purchase. [quoting Humana, Inc. v. Heckler, 758 F. 2d 696, 705 (D.C. Cir. 1985)]

---

requirement that all amendments to the Budget Bill be germane. See Rules of the New York State Assembly, Rule III, § 6(d), attached as Provider Exhibit 15. Medicaid regulations in place on November 24, 1997, already provided that no hospital in New York State could claim a loss on sale. 10 N.Y.C.R.R. § 86-1.32. Pursuant to those regulations, the Providers did not claim a loss on sale for Medicaid See Provider Exhibit 16, copies of the relevant pages of the Medicaid cost reports for 1997 filed by each Provider, showing on Exhibits 14 and 13, Part III that they did not claim a loss on sale. Thus, the provision regarding Medicaid merely confirmed existing law.

[19] Providers' Responsive Brief at 12-14.

[20] Providers' Exhibit 1.

PIA-Asheville, Inc. v. Bowen, 850 F.2d 739 (D.C. Cir. 1988).

It is important to note that when there is a two-step transaction involving a stock purchase followed by a liquidation or merger, the event that triggers the recognition of gain or loss (as well as the change in depreciable basis for the purchaser) for Medicare purposes is the *first* transaction. This is clear from the district court decision in the case of Pacific Coast Medical Enterprises v. Califano, 440 F. Supp. 296, 306 (C.D. Calif. 1977), aff'd 633 F.2d 123 (9th Cir. 1980) where the court stated that the purchase of "one hundred percent of the stock of Community Hospital on May 30, 1969" constituted a purchase for Medicare payment purposes.[21] Indeed, the facts of the case at hand are more compelling since the transaction closed on November 24, 1997 and, at that point, the parties were powerless to reverse the transaction. In contrast, in Pacific Coast Medical Enterprises, the court found the date of the stock purchase to be the effective date based only on the "power" of the stock owner to liquidate the acquired corporation at any time, and its "intent " to do so.[22]

Another relevant case was decided by this Board, Baptist Memorial Hospital v. Blue Cross and Blue Shield Association/Blue Cross and Blue Shield of Texas, PRRB Dec. No. 85-D82, July 24, 1985, Medicare and Medicaid Guide (CCH) ¶ 34,916, July 24, 1985, rev'd CMS Adm'r, September 19, 1985, Unreported. In that case, the issue was whether a hospital had to use its funded depreciation available in 1980, when it exercised an option to purchase its facility from the landlord. In 1969, a new hospital had donated its property to a developer (Mr. Adair) to construct and finance a facility and entered into several binding contracts with him, including one that required him to lease the completed facility to the provider beginning November 1, 1979 and another giving the provider the option to purchase the facility at various times, the earliest of which was approximately 10 years later (i.e., in 1980). The hospital exercised its option in 1980 and purchased the facility with an assumption of the debt that Mr. Adair had incurred in 1969 to construct the facility. The intermediary disallowed the interest on the assumed debt on the ground that the hospital had sufficient funded depreciation at the time of the 1980 transaction to pay cash and it did not need to assume the developer's debt. The hospital argued that the 1980 exercise of its option to purchase was not a new transaction that could be viewed separately, but rather was the second step of the 1969 transaction, and hence the availability of funded depreciation had to be measured as of the date the initial transaction had been entered into, i.e., 1969. The Board agreed and in holding in the provider's favor stated:

> [t]he unusual circumstances of this case demonstrate that the provider had for all intents and purposes effectively

---

[21] It is equally clear in PIA-Asheville, Inc. v. Bowen that the effective date for the reimbursement consequences flowed from the date of the stock acquisition and not the following liquidation. PRRB Dec. No. 86-D28, Medicare & Medicaid Guide (CCH) ¶ 35,304.

[22] Pacific Coast Medical Enterprises, 440 F. Supp. at 306.

> retained ownership of the facility. It finds that the simultaneous issuance of the contracts for transferring the land to Mr. Adair concurrent with the leaseback of the facility by Mr. Adair along with the option to purchase and assignment of lease and payments to the mortgagee of the property effectively and substantively results in the purchase of the facility by the provider.

Id. at 9506.

Thus, the Board deemed the provider to be the beneficial owner of the hospital assets as of 1969 because of binding agreements entered into in 1969 even though the legal title to those assets was held by an unrelated third party from 1969 to 1980. Similarly, in this instance the binding agreements for which there was a closing on November 24, 1997 must be given effect as of the closing date.

Contrary to various assertions by the Intermediary, the Providers are not arguing that the merger was complete on November 24, 1997. Rather, the Providers contend that ownership of their depreciable assets was transferred to Kaleida Health when the Memorandum of Closing was executed, rather than on the date that the merger was completed.

The Intermediary cites to various provisions of New York's Not-for-Profit Corporation Law ("N-PCL"):

Section 403 provides that corporate existence begins when the Certificate of Incorporation is filed with the Secretary of State. Kaleida Health's Certificate was filed December 6, 1996. It was in existence on November 24, 1997, and thus, Kaleida was a party to the Memorandum of Closing.

Section 902 provides that parties to a merger must adopt a plan of merger. The Agreement and Plan of Merger was such an agreement, properly adopted by the Board of Directors of each constituent entity. See Sections 4.2, 5.2, 6.2 and 7.2 of the Agreement and Plan of Merger in Providers Exhibit 1.

Section 904 provides that a Certificate of Merger be signed on behalf of each constituent corporation and delivered to the Secretary of State. The Certificate of Merger[23] was one of the documents that was signed by the constituent corporations at the closing-in-escrow on November 24, 1997, and held by the escrow agent.

Section 905(a) states that a merger will be effected when the Certificate of Merger is filed with the Secretary of State. The escrow agent filed the Certificate of Merger on March 31,

---

[23] Providers' Exhibit 10.

1998. The Providers do not contend otherwise. Rather, they contend that ownership of their depreciable assets was transferred, by operation of law, prior to completion of the merger. This is true under New York common law, and under New York's statute that confirms the common law conclusion. Any attempt by the Intermediary to argue that, under the N-PCL, ownership of the assets could not have occurred until the Certificate of Merger was filed is overcome by the state statute, which provides that execution of the Memorandum of Closing effected a change in ownership of the assets, notwithstanding any other provision of state law.[24]

With respect to the Intermediary's position that no disposition of the Providers' assets could have occurred prior to December 1, 1997, because the entity that received the assets (i.e., Kaleida Health) did not come into existence until some time in 1998, the Providers counter that the Intermediary has misconstrued the facts.[25]

CMG (now called Kaleida Health)[26] was formed as a New York State not-for-profit corporation on December 6, 1996, when its Certificate of Incorporation was filed with the Secretary of State of New York.[27] The corporation received its 501(c)(3) tax exemption determination letter from the IRS on November 19, 1997.[28] The corporation was a party to both the Agreement and Plan of Merger executed on August 1, 1997 and the Memorandum of Closing executed on November 24, 1997.

Thus, Kaleida Health had existed as a valid New York not-for-profit corporation since December 6, 1996; nearly a year before the merger parties executed the Memorandum of Closing on November 24, 1997. Kaleida Health was not created by the merger, but was the surviving corporation in the merger. On November 24, 1997, by virtue of New York's equitable conversion doctrine, Kaleida Health became the equitable owner of the Providers' assets.

---

[24] Opinion Letter from Counsel to the Majority New York State Assembly and Legislative Counsel, New York State Senate, Providers' Exhibit 26.

[25] Intermediary's Paper at 16.

[26] In the Certificate of Merger filed with the Secretary of State of New York on March 31, 1998, the corporation changed its name to CGF Health System. Providers Exhibit 10. Subsequently, the corporation amended its Certificate of Incorporation to change its name to Kaleida Health. Provider Exhibit 11. In this Response, the corporation formed in 1996 will be referred to as Kaleida Health, unless the context requires otherwise.

[27] Providers' Exhibit 8.

[28] Providers' Exhibit 9.

The Providers also note that the Intermediary was concerned that the entity that received the assets was not a Medicare Provider. The Providers note that Medicare loss-on-sale rules do not require that the transferee of depreciable property be a certified Medicare provider. See, e.g., CMS Adm'r decision in Fort Pierce, where property was transferred from a hospital to a housing authority. The loss-on-sale regulations apply to scrapping, demolition, condemnation, fire, theft, or other casualty, as well as to transfers to another user (42 C.F.R. 413.134(f)(1)), and such property by definition is not transferred to a Medicare provider. The Intermediary agrees that the transferee of depreciable assets need not be a certified Medicare provider in order for the transferor to claim a loss on the asset disposition (Intermediary's Paper at 16, referring to a sale to "a party who intends to raze the hospital and build homes in its place"). Therefore, the fact that Kaleida Health was not yet a certified Medicare provider on November 24, 1997 is irrelevant for purposes of the Providers' loss-on-sale claim.

With respect to the Intermediary's concerns about the Providers' submission of cost reports, the Providers contend that their submission of cost reports was consistent with their assertion that they conveyed their assets to Kaleida Health on November 24, 1997. The Intermediary argues that, to be consistent in their position that asset ownership changed on November 24, 1997, the Providers should have filed final short-year cost reports for the period January 1, 1997 through November 23, 1997, and claimed on those reports any loss on the disposition of their assets.[29] This argument assumes that disposition of depreciable assets automatically triggers a change in ownership of the provider that would require filing of a final cost report. The Providers argue that this is clearly not correct. An existing provider can dispose of depreciable assets and continue in existence as a provider, with no change of ownership and no final cost report. See, e.g., Emanuel Medical Center v Blue Cross and Blue Shield Association/ Blue Cross and Blue Shield of California, PRRB Dec. No. 98-D21, January 16, 1998, Medicare and Medicaid Guide (CCH) ¶ 46,010, CMS Adm'r decline review, Feb 24, 1988 (provider sold a facility, remained in operation, and was entitled to claim a loss on sale for the disposition of the facility). In such a situation, the provider would claim, on its annual cost report, any loss or gain on the disposal of the assets during that fiscal year. That is exactly what the Providers did on their FYE 12/31/97 cost reports, and their filing of those reports is completely consistent with their position that they disposed of their depreciable assets on November 24, 1997.[30]

---

[29] Intermediary's Paper at 17.

[30] The Provider notes that the Intermediary is incorrect in its assertion that the Providers did not file cost reports for the period January 1, 1997 through November 24, 1997. On April 22, 1998, each Provider did file such a report. Evidence of such filing is attached as Exhibit P-12. On April 27, 1998, prior to the date on which Kaleida Health would have filed a cost report for the short period 11/24/97 through 12/31/97, the CMS Regional Office issued a tie-in notice to Kaleida Health, indicating that CMS considered the date of ownership change of the Providers to be April 1, 1998. A copy of the tie-in notice is attached as Exhibit P-13. In accordance with this determination, each Provider then filed a cost report for the full calendar year ending December 31, 1997 (Exhibit P-2) These cost reports included the Providers' claims

The Providers argue, in the alternative, that the regulation that eliminates recognition of gain or loss on asset sales on or after December 1, 1997 is invalid, and the Providers are entitled to losses on disposition of their assets regardless of the date on which that disposition occurred.[31]

INTERMEDIARY'S CONTENTIONS:

The Provider hospitals do not qualify for Medicare reimbursement for a loss on sale of depreciable assets because no disposal of their assets to Kaleida Health took place on or before December 1, 1997 or could have taken place until March 1998 when the Providers filed the Certificate of Merger required under New York State's statute governing not for profit organizations.

The facts are indisputable that the Providers never filed the most important document to effectuate their planned merger; namely, the Certificate of Merger before December 1, 1997 when the BBA 97 conforming regulation went into effect. Without Kaleida's being established as a legitimate corporation with the constituent corporations merged into it, the Providers had no entity to which they could dispose their depreciable assets. The planned corporation simply did not yet exist. This is not a situation where a hospital sells its assets on November 24, 1997 to a party who intends to raze the hospital and build homes in its place and the hospital dissolves, goes out of business on November 30, 1997. Under this set of facts, a provider would be eligible for relief under the rules in effect before the BBA 97 regulation was published and made effective.

These Providers continued their business as independent corporations until the Certificate of Merger was approved, which Kaleida itself placed at April 1998. The Intermediary argues that it strains credulity to accept that providers can dispose of depreciable assets when the critical, indispensable piece of the enterprise -- the leader of the merged entities -- has not yet even come into legal existence insofar as the State's Not-for-Profit Law is concerned. Failure to have an approved Certificate of Merger doomed the Providers' ability to make a successful run at obtaining Medicare reimbursement under the pre-BBA 97 era.

The Provider Hospitals' submission and content of their Medicare cost reports are consistent with their own understanding that the contemplated change of ownership under which their assets would convey to Kaleida did not take place until at least March 31,1998 when they filed the Certificate of Merger.

Independent hospitals that merge are considered by the Medicare Program, as Kaleida argues, to have gone through a change of ownership. Providers that change ownership must submit final cost reports as of the last date of their operation. As stated above, until the BBA 97

---

for losses on the disposition of depreciable assets, since the Providers believe the asset disposition occurred on November 24, 1997, regardless of the date on which ownership of the providers changed for purposes of Medicare certification.

[31] Providers' Final Position Paper at 8-9.

retired the provision for sharing in gains or losses on disposition of depreciable assets resulting from a change of ownership or sale of assets, any such claims were properly made in the Providers' final cost reports as part of (or as an adjustment to) termination costs.

The complainants say that the disposition of the facilities' assets took place on November 24, 1997. If that were the case, each of the four hospitals involved in the merger should have filed termination Medicare cost reports for the period January 1, 1997 through November 23, 1997. Any losses under the change in ownership should have been claimed on each of those cost reports. Then the newly merged and state approved hospital corporation would have filed a cost report for the short period November 24, 1997 through December 31, 1997.

However, each of the four hospitals filed individual cost reports for the period January 1 through December 31, 1997 and claimed losses on sale on those reports, even though they were not the required termination cost reports. Then they filed short period reports for the period January 1 through March 31, 1998 [32] and Kaleida filed a consolidated report for April 1 through December 31, 1998. The manner in which the Providers and the new Corporation treated their cost reporting obligations is consistent with the Intermediary's position that Kaleida as the surviving corporation of the merger was not in existence as a matter of law until the New York State Department approved a Certificate of Merger filed by the four constituent corporations, the Providers. This clearly did not occur until March-April 1998, well after the effective date of the BBA 97 regulation, December 1, 1997. Neither the predecessor hospitals nor Kaleida filed Medicare cost reports consistent with their assertion that a disposition of assets occurred on November 24, 1997. Indeed, all of the parties proceeded with filing Medicare cost reports in a manner that effectively concedes April 1, 1998 as the effective merger date when a disposition of assets could legitimately occur. Whether the Providers' Agreement and Plan of Merger dated August 1, 1997 and their November 24, 1997 Memorandum of Closing, viewed separately or taken together, are enforceable agreements under New York State statutory or common law is irrelevant to whether § 4404 of the Balanced Budget Act of 1997 applies to the Providers' transaction.

BBA 97 included no exceptions to the new rules for treating costs related to the disposition of depreciable assets. The New York statute was an *ex post facto* attempt to place the Providers in a position which was the very opposite of where they stood as a matter of state and federal law on November 24, 1997 and on December 1, 1997. The federal government cannot recognize a cure that conflicts with several of the state's statutes when the federal Congress has clearly determined how the Medicare Program is to be administered with respect to reimbursement for capital indebtedness.

The New York common law doctrine of equitable conversion is equally irrelevant. While the Provider raises Fort Pierce, supra, to support its view that CMS has accepted that doctrine, a close reading of the case shows a unique set of facts. A better reading of the agency's regard for the doctrine is reflected in the Administrator's decision in Central Hospital, supra, in which he reversed three Board decisions. Although the case arose under Deficit Reduction

---

[32] Intermediary Exhibit 19 includes an example.

Act of 1984 ("DEFRA"), it addresses a key problem presented in this case: when a contract among or between parties has so many unsatisfied critical contingencies that the parties themselves established, it has defeated enforcement by its own terms. In other words, parties can bargain away any "rights at common law" they may have to invoke the doctrine of equitable conversion. It is patently clear from the August Agreement and the November Memorandum that the parties associated with this enterprise covered virtually every detail conceivable regarding the actions necessary to establish the Kaleida Health System. Given the degree of specificity, it seems almost arrogant to suggest that the parties now may be sheltered under the cloak of a common law doctrine that they essentially bargained away.

Furthermore, invocation of or reliance on any such doctrine is clearly superfluous, when a thorough New York statutory scheme existed to make unnecessary resort for relief or direction to any common law doctrine. When such a clear and thorough statutory scheme as New York's is in place, reliance on common law remedies is misplaced.

Kaleida's own press materials and others covering Kaleida refer to 1998 as the date of the merger and change of ownership. The record is self-evident that the planned merger did not occur until April 1998, and moreover, that the critical document, the Certificate of Merger, was not filed with the New York Department of State until March 1998.[33] With no approved Certificate of Merger, no merger occurred on November 24, 1997, and the intended entity to receive the assets did not exist, foreclosing any possibility that the Providers disposed of their assets and incurred a loss. No disposition took place until the state approved the merger.

At the hearing, the Intermediary noted that the Provider was claiming that a legitimate sale took place on November 24, 1997, in-so-far as the Memorandum of Agreement called for depositing all of the assets that belonged to the four hospitals either into escrow or transfering them to Kaleida.[34] The Intermediary pointed out that if the Providers were claiming that a legitimate sale took place, it had to meet the bona fide test.[35] The Intermediary indicates that they have seen no appraisal, no sales document, no indication of the purchase price of the assets or what assets were in fact transferred.[36] The Intermediary argues that the Providers' reliance on 42 C.F.R. § 413.134(f) ignores the underlying transaction. The Intermediary indicates that the Provider does not deny that the transaction is a statutory merger[37] defined as a combination of two or more corporations under the corporation laws of the state with one of the corporations surviving.[38] The surviving corporation acquires the assets and liabilities of

---

33 Intermediary Exhibit 15.

34 Transcript ("Tr.") at 38-39.

35 Tr. at 39.

36 Tr. at 39-40.

37 Tr. at 41.

38 Tr. at 42.

the merged corporation by operation of state law.[39] The Intermediary points out that a statutory merger results in a change of ownership.[40] It cites to the legislative history concerning a stock purchase not qualifying as a change of ownership because the two separate legal entities continue to exist.[41] In contrast, a statutory merger of the Providers into another corporation does constitute a change in ownership.[42]

CITATIONS OF LAWS, REGULATIONS AND PROGRAM INSTRUCTIONS:

1. Laws - 42 U.S.C.:

§ 1395x(v)(1)(A)	-	Reasonable costs
§ 1395x(v)(1)(O)	-	Allowance for Depreciation and Interest

2. Regulations – 42 C.F.R.:

§§ 405.1835-.1841	-	Board jurisdiction
§ 405.1867	-	Sources of Board's Authority
§ 412.302(c)(2)	-	Lengthy certificate-of-need process
§ 413.134 et seq.	-	Depreciation: Allowance for depreciation based on asset costs

3. Provider Reimbursement Manual (HCFA Pub. 15-1):

§ 233.3.D	-	Interest expense on refunded debt
§ 2162.3	-	Self Insurance

---

39 Tr. at 42-43.

40 Tr. at 53.

41 Tr. at 54-55.

42 Tr. at 67.

§ 2162.7	-	Conditions applicable to self insurance
§ 2807.3	-	Distinguishing between new and old capital costs during the transition period

4. Cases:

Albany Medical Center Hospital v. Blue Cross Association/Blue Cross of Northeastern New York, PRRB Dec. No. 78-D43, June 16, 1978, Medicare and Medicaid Guide (CCH) ¶ 29,215, aff'd, CMS Adm'r, August 15, 1978, Medicare and Medicaid Guide (CCH) ¶ 29,242.

AMISUB Inc. v. Shalala, 12 F.3d 840 (1994).

Baptist Memorial Hospital v. Blue Cross and Blue Shield Association/Blue Cross and Blue Shield of Texas, PRRB Dec. No. 85-D82, July 24, 1985, Medicare and Medicaid Guide (CCH) ¶ 34,916, July 24, 1985, rev'd CMS Adm'r, September 19, 1985, Unreported.

Central Hospital v. Blue Cross and Blue Shield Association/Blue Cross and Blue Shield of Massachusetts, Dec. No. 97-D18, D-19, D-20, December 30, 1996, Medicare and Medicaid Guide (CCH) ¶ 45,015, rev'd, CMS Adm'r Dec., Nov. 22, 1983, Medicare and Medicaid Guide (CCH) ¶ 45,179.

Emanuel Medical Center v Blue Cross and Blue Shield Association/ Blue Cross and Blue Shield of California, PRRB Dec. No. 98-D21, January 16, 1998, Medicare and Medicaid Guide (CCH) ¶ 46,010, CMS Adm'r decline review, Feb 24, 1988.

Fort Pierce Memorial Hospital v. Blue Cross and Blue Shield Association/Blue Cross of Florida, PRRB Dec. No. 83-D154, Sept. 28, 1983, Medicare and Medicaid Guide (CCH) ¶ 33,582, aff'd, CMS Adm'r Dec., Nov. 22, 1983, Medicare and Medicaid Guide (CCH) ¶ 33,603.

Nursing Center of Buckingham and Hampden v Shalala, 900 F.2d 645 (D.C. Cir. 1993).

Pacific Coast Medical Enterprises v. Califano, 440 F. Supp. 296 (C.D. Calif. 1977), aff'd 633 F.2d 123 (9th Cir. 1980).

PIA-Asheville, Inc. v. Bowen, 850 F.2d 739 (D.C. Cir. 1988).

5. Other:

The Balance Budget Act of 1997, P.L. 105-33 § 4404.

Deficit Reduction Act of 1984, P.L. 98-369.

44 FR 6912 (Feb. 5, 1979).

56 Fed. Reg. 43358 (August 30, 1991).

63 Fed. Reg. 1382 (January 9, 1998).

Section 56 of Chapter 82 of New York State Chapter Laws of 2002.

10 N.Y.C.R.R. § 86-1.32.

Rules of the New York State Assembly, Rule III, § 6(d).

New York Mental Hygiene Law §§ 1.03 and 31.02.

New York Not-for-Profit Corporation Law §§ 403, 902, 904, 905.

New York Public Health Law § 2801(l).

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board, after consideration of the facts, parties' contentions in their briefs and at the hearing, finds and concludes as follows:

It is undisputed that this transaction is a statutory merger as defined in 42 C.F.R. § 413.134(l)(2). Medicare rules define a statutory merger as the combination of two or more corporations under the corporation laws of the State with one of the corporations surviving. Id. The Board finds that federal law does provide guidance concerning when assets change ownership in a merger. Both the Medicare regulation and New York not-for-profit corporation law specify that in a merger asset ownership change occurs with the filing of the certificate of merger, which in this case occurred on March 31, 1998. New York common law therefore does not apply to this merger. The Board further finds that subsequent New York law recognizing the signing of the binding Memorandum of Closing as a change of ownership of assets as of November 24, 1997, is inconsistent with federal law and does not affect when the change of ownership of assets took place.

The Medicare regulation at 42 C.F.R. § 413.134(l)(2) defines a statutory merger. It states:

> [a] statutory merger is the 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 mergers between unrelated parties . . . may be revalued in accordance with paragraph (g) of this subsection.

42 C.F.R. § 413.134(l)(2).

The Board notes that the regulation refers to the combining occurring "under the corporation laws of the State." The regulation also indicates that it is the "surviving corporation" that acquires the assets and liabilities of the "merged corporations" by operation of State law. The Board views this language as important because it recognizes that the change in ownership for revaluation purposes occurs when the merger occurs, that is, when the surviving corporation takes over under state corporation law. The preamble to the regulation establishing the statutory merger section further addresses this issue. 44 Fed. Reg. 6912 (Feb. 5, 1979). In the preamble, the Secretary addresses why a transfer of stock is not treated as a change of ownership and why a statutory merger is treated as a change of ownership. It states that:

> [s]ince assets are properly revalued only if there has been a change of ownership, this rule [not permitting revaluation of stock transfers] follows from the basic principle of corporate law that a transfer of corporate stock does not constitute a change of ownership of the corporate assets. A corporation and its stockholders are distinct legal entities with title to the corporate property vested in the corporation itself, and not in the stockholders. Only if the assets are transferred by means of a bona fide transaction between unrelated parties would revaluation take place. Medicare regulations are consistent with this view. 42 CFR 405.6269(c) states that a transfer of corporate stock does not in itself constitute a change of ownership for purposes of terminating a provider agreement. The existing provider agreement continues in effect and we, therefore, see no valid reason to change the basis for determining Medicare reimbursement to the provider.
>
> With regard to statutory mergers, the new paragraph (l) provides that if the merger is between unrelated parties, the assets of the merged corporation may be revalued. This rule differs from the rule for provider stock transactions because, while the acquisition of capital stock does not effect the legal status of the corporation, <u>in a merger, the merged corporation ceases to exist as a corporate entity. In a merger the surviving corporation does not become a mere stockholder but takes over the merged corporation entirely. Since the merged corporation no longer exists, there has indeed been a transfer of ownership and revaluation is proper</u>.

44 Fed. Reg. 6912-13 (Feb. 5, 1979) (emphasis added).

The Board believes that the Secretary was adopting for Medicare reimbursement purposes the basic corporate law concept that assets of a corporation are transferred when the surviving corporation takes over the merged corporations. The merging corporations simultaneously

cease to exist and, by operation of state law, the surviving corporation obtains their assets and liabilities.

The Board observes that the New York Not-for-Profit Corporation Law (N-PCL) appears to adhere to this principle. Article 9, entitled "Merger and Consolidations," and specifically Section 905, entitled "Effect of merger or consolidation," is consistent with the Secretary's interpretation of the effects of a merger as expressed in the regulation. It states:

> (c) Upon the filing of the certificate of merger and consolidation by the Department of State or on such date subsequent thereto, not to exceed thirty days, as shall be set forth in such certificate, the merger or consolidation shall be effected.
>
> (d) When such merger or consolidation has been effected:
>
> (1) Such surviving or consolidated corporation shall thereafter, consistent with its certificate of incorporation as altered or established by the merger or consolidation, possess all rights, powers and purposes of each of the constituent corporations.
>
> (2) All property real and personal, including causes of action, and every other asset of each of the constituent corporations shall vest in such surviving or consolidated corporation without further act or deed . . .
>
> (3) The surviving or consolidated corporation shall assume and be liable for all the liabilities, obligations and penalties of each of the constituent corporations.

(emphasis added).

State law, like the regulation, specifies how statutory mergers are to be treated. Mergers trigger a change in ownership because the old corporations no longer exist and the surviving corporation takes over ownership of the assets.

The Board also notes that the parties' Agreement and Plan of Merger and the Closing Memorandum reference the same effects taking place with the effective date of the merger. In the Agreement and Plan of Merger, in Article 1, entitled "Definition, Usage, Etc.," Section1.1, entitled "Definitions" at subsection(j) it states that the "Effective Date" shall mean the date on which the Merger shall become effective as provided for in Section 2.4." In Article 2, entitled "Plan of Merger" is Section 2.4 entitled "Terms of Merger" which states in relevant part:

> [t]he effective date of the Merger shall be the date on which the Certificate of Merger is filed with the New York Department of State or such later date as may be specified in said Certificate of Merger which date will be specified by the President of CFG, but not later than 30 days after the filing date of the Certificate of Merger.

It should also be noted that Section 2.4(f) states that:

> [a]t the effective date the separate existence of [the Providers] shall cease and said Constituent Corporations shall be merged with and into CFG, as the surviving Corporation, which shall possess all of the rights, privileges, powers and purposes of each of the Constituent Corporations. The effect of the Merger shall otherwise be the effect described in Section 905 of the NPCL (Non-for-Profit Corporation Law of the State of New York.)

The Board notes that Article 3, entitled "Additional Actions," indicates that "[i]n order to effectuate the Merger of the Constituent Corporations and their Affiliated Companies, the following actions must be taken prior to the effective date" and then lists some six governmental agencies.

The Board further notes that in the Memorandum of Closing, in Section 4.3 it states:

> [e]ach of the Constituent Corporations intended that this Memorandum of Closing shall evidence that the Constituent Corporations are legally bound to complete the Merger upon receipt of the Governmental Approvals and Financing Approvals (the only remaining conditions to the Merger) and that, except for such approvals (and the filing of the Certificate of Merger), the Merger has been completed.

Although the Providers have bound themselves to completing the merger, the Board finds that the agreements acknowledge that the merger, in fact, will not take place until the approvals are obtained and the Certificate of Merger is filed.

Because the Providers chose statutory merger as the vehicle for transferring assets, the Board finds that it must apply special rules the Secretary has specified regarding mergers. Consequently, the Board does not believe that common law principles concerning passage of equitable title of realty apply. Even though the Providers completed all of the necessary documents subject to their control and placed them in escrow, the merger was not completed until after the governmental approvals were obtained and the Certificate of Merger pursuant to New York state corporation law was filed.[43]
The Board also notes that subsequent NY law recognized a change of ownership of assets on November 24, 1997. The Board finds, however, that Medicare rules regarding merger apply

---

[43] The Board notes that Nursing Center of Buckingham and Hampden v. Shalala, 900 F.2d 645 (D.C. Cir. 1993), involved a merger in which the issue of whether the agreement to merge was a binding contract was dispositive of how depreciation was treated by Medicare. However, that case involved a deadline under DEFRA, which specifically excluded from the deadline, transactions in which the parties had entered into a binding contract before the effective date of the statute.

in this case. They require that there be a merger under state corporation law, and such merger did not take place until the Certificate of Merger was filed.

The Board having determined that the statutory merger rules require that the merger take place to effectuate a change of ownership of assets, finds that the concerns regarding when the Providers claimed loss on their costs reports and the corporate powers of CMG are not material to the Board's decision.

Finally, the Board also acknowledges that it can not consider the Providers' alternative argument that the regulation that eliminates recognition of gain or loss on asset sales on or after the December 1, 1997 is invalid. See 42 C.F.R. § 405.1867.

DECISION AND ORDER:

The Intermediary's adjustments denying the Providers' loss on sale were proper. The Intermediary's adjustments are affirmed.

Board Members Participating:

Suzanne Cochran, Esquire
Henry C. Wessman, Esquire
Stanley J. Sokolove
Gary Blodgett, D.D.S

DATE OF DECISION: November 5, 2002

FOR THE BOARD:

Suzanne Cochran, Esquire
Chairman