PROVIDER REIMBURSEMENT REVIEW BOARD
HEARING DECISION

2005-D8

PROVIDER –
Bon Secours Venice Healthcare
Venice, FL

Provider No. 10-0070

vs.

INTERMEDIARY –
Blue Cross Blue Shield Association/
First Coast Service Options, Inc.

DATE OF HEARING –
October 9-10, 2003

Cost Reporting Periods Ended
August 31, 1996
August 31, 1997
August 31, 1998

CASE NOs. 00-1542
01-1278
03-0040

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ISSUE:

Were the Intermediary's adjustments to interest expense relating to the acquisition of medical records and an assembled work force proper?

STATEMENT OF THE CASE AND STATUTORY AND REGULATORY BACKGROUND:

This case arises from a Medicare payment dispute. The Medicare program was established to provide health insurance to the aged and disabled. 42 U.S.C. §§1395-1395cc. The Centers for Medicare and Medicaid Services (CMS, formerly the Health Care Financing Administration (HCFA)) is the operating component of the Department of Health and Human Services (DHHS) charged with administering the Medicare program. CMS' payment and audit functions under the Medicare program are contracted out to insurance companies known as fiscal intermediaries. Fiscal intermediaries determine payment amounts due the providers under Medicare law and under interpretive guidelines published by CMS. See, 42 U.S.C. § 1395(h), 42 C.F.R. §§ 413.20(b) and 413.24(b)

At the close of its fiscal year, a provider must submit a cost report to the fiscal intermediary showing the costs it incurred during the fiscal year and the proportion of those costs to be allocated to Medicare. 42 C.F.R. §413.20. The fiscal intermediary reviews the cost report, determines the total amount of Medicare reimbursement due the provider and issues the provider a Notice of Program Reimbursement (NPR). 42 C.F.R. §405.1803. A provider dissatisfied with the intermediary's final determination of total reimbursement may file an appeal with the Provider Reimbursement Review Board (Board) within 180 days of the issuance of the NPR. 42 U.S.C. §1395oo(a); 42 C.F.R. §405.1835.

Bon Secours Venice Healthcare (Provider), located in Venice, Florida, is a member of the Bon Secours Health System. In August 1995, Bon Secours Health System acquired the Provider pursuant to an asset purchase agreement for $ 86,000,000.[1] The seller engaged an independent firm, Valuation Counselors, to value the assets to be sold in the transaction.[2] The appraisal report included a valuation of certain intangible assets, among which were medical records valued at $ 5.1 million and an assembled work force valued at $ 4.76 million.[3] In its cost reporting year ended August 31, 1996, the Provider treated the medical records and assembled workforce as non-depreciable capital assets that were related to patient care. The Provider claimed as an allowable Medicare cost the portion of interest expense incurred on its financing that related to the funding of their acquisition. The Intermediary disallowed the interest expense based on a determination that the assembled workforce and medical records did not represent assets of any patient care or other value.[4] The Intermediary's treatment of these costs was identical in fiscal

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1 Provider Exhibit P-11 & P-13. (FY 1996 case/00-1542).
2 Provider Exhibit P-27/Appraisal Report (FY 1996 case/00-1542)
3 Provider Exhibit P-27 & P-29 Id.
4 Intermediary Exhibit I-1

years 1997 and 1998. The Provider timely appealed the cost report adjustments relating to the three years to the Board and has met the requirements of 42 C.F.R. §§ 405.1835-1841. The amount of Medicare program funds in dispute is approximately $ 650,000.

The Provider was represented by Dennis M. Barry, Esq. and Andrew D. Ruskin, Esq. of Vinson & Elkins, L.L.P. The Intermediary was represented by Bernard M. Talbert, Esq. of the Blue Cross Blue Shield Association.

PARTIES' CONTENTIONS:

The Provider asserts that both the medical records and the assembled workforce are related to patient care, and thus the interest expense attributable to them should also be deemed allowable. The medical records are clearly related to patient care in that they provide important continuity to the Provider's ability to deliver uninterrupted high-quality care to patients in the community. The Provider states that the assembled workforce is also an essential component of the provision of quality care.

The Intermediary relies on the accounting practices of the Provider and the seller to support its position that medical records and the assembled workforce were not related to patient care. The Intermediary asserts that these were never recorded on the balance sheet of the seller.[5] Additionally, the Intermediary states that it is inconsistent for the Provider to expense current medical records as an operating cost, but capitalize the prior medical records for the purpose of securing interest expense reimbursement on the Medicare cost report. The Intermediary views these costs as similar to goodwill, which it defines as the amount paid in excess of the actual assets acquired. In support of its position the Intermediary points to Dakota Midland Hospital v. Blue Cross Blue Shield of Iowa/Blue Cross Blue Shield Association, PRRB Dec. No. 97-D72, wherein the Board stated that "the transferring of patient records and maintaining a work force were part of the seller's obligation or conditions necessary for the sale to close. They are not quantifiable assets."[6]

In addition, the Intermediary points to Accounting Principles Board (APB) – 16, Paragraph 88, Subparagraph (e), which covers intangible assets. The Intermediary asserts that all the assets listed in this section have characteristics of severability, but the Provider has not demonstrated how the assembled workforce and medical records of a going concern hospital could have any severable value, The Intermediary also points to Financial Accounting Standards Board (FASB) Statement 141, Paragraph 30 which states that " . . . For purposes of this Statement, an assembled workforce shall not be recognized as an intangible asset apart from goodwill." With respect to the issue of severability, the Provider maintains that it is not relevant and that the assets' relationship to patient care should be the overarching consideration.

At the hearing, the Provider raised an alternative argument regarding the appraisal report. The Provider contends that the Intermediary had always considered the allocation to be

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5 Intermediary Exhibit 6 of FI Supplemental Position Paper dated October 2, 2003

6 Intermediary Exhibit 2 in PRRB Case No. 01-1278

suspect and did not believe that the assets were meaningfully supported by the appraisal report. In addition, the Provider cites a number of flaws in the methodology used to allocate value to assets in the appraisal report. The Provider maintains that the appraisal report should be considered deficient and discarded for the purpose of allocating sales price among the assets sold and net book value should be used in the absence of an acceptable appraisal. The Provider cites Sullivan Community Hospital v. Blue Cross and Blue Shield Assoc., CMS Admin. Dec., June 24, 1994, Medicare and Medicaid Guide (CCH) ¶ 42,569 in which the Administrator examined whether it was proper to challenge a purchase price allocation to which it had agreed. The Administrator determined that the appraisal supporting the agreement did not contain sufficient documentation of the fair market value of the assets sold. Thus, the Administrator held that the allocation was to be discarded.

In response to this alternative argument, the Intermediary argues that there is no valid basis to revalue the assets in this case and points to two court cases in support of its position. See Vallejo General Hospital v. Bowen, 851 F.2d 299, (9th. Cir. 1988), and Peninsula Medical Center v. Blue Cross Blue Shield of Florida/Blue Cross Blue Shield Association, PRRB Dec. No. 94-D62. With respect to Sullivan Community Hospital v. Blue Cross and Blue Shield Association, the Intermediary argues that the agreement in that case was not the neat, clear, integrated agreement that the instant case represents and that the appealing party in that case challenged the finding that there was an agreement immediately, not almost eight years after it was signed.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

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

The Board finds that the key question is whether the assembled work force and medical records are, in fact, assets to which an individual value can be assigned. Unfortunately, there are no Medicare laws or regulations dealing with this specific issue. Instead, the Board must consider other facts and evidence in reaching its determination

First, the Board noted that the excess of cost over the identifiable assets acquired was treated as goodwill on the Provider's financial statements. Furthermore, the Provider did not claim any amortization relating to the assembled work force or the medical records on its Medicare cost reports. This indicated to the Board that the assets in question would not be related to patient care.

Second, the record did not contain any evidence of employment contracts which would support the Provider's characterization of the assembled work force as a separate, quantifiable asset. Nor did the record reflect any evidence that the acquired medical records would be of any value except as part of the operation of the Provider as a going concern.

The Board also considered the Financial Accounting Standards Board (FASB) Statement 141 at paragraph 39[7] which states:

> For purposes of this Statement, an assembled work force shall not be recognized as an intangible asset apart from goodwill.

The Board also points to its decision in Dakota Midland Hospital, supra. In that case, the Board stated:

> The Board is not persuaded by the Provider's argument that there were intangible assets, even in light of the Provider's independent appraisal, which attached a value to intangible assets. The transferring of patient records and maintaining the work force were part of the seller's obligations or conditions necessary for the sale to close. They are not quantifiable assets.

Based on the factors noted above, the Board finds that the assets in question are not quantifiable, and individual values can not be assigned to them. As such, the interest expense related to the acquisition of these assets is not allowable.

As an alternative, the Provider argued that the original appraisal was flawed and should now be ignored. In its place, the Provider suggests that a more reasonable basis for revaluing the assets would be to use the net book value at the time of the acquisition. The Board has considered the alternative argument advanced by the Provider and finds it to be without merit.

The regulation at 42 C.F.R. § 413.134(f)(2)(iv) states in part:

> . . . the intermediary for the selling provider shall require an appraisal by an independent appraisal expert to establish the fair market value of each asset and shall make an allocation of the sale price in accordance with the appraisal.

Further, the regulation at 42 C.F.R. § 413.134(g)(3) requires a buyer to use the same values as the seller and states in part:

> . . . historical cost may not exceed the lowest of the following:
>
> (i) The allowable acquisition cost of the asset to the owner of record . . . ;
> (ii) The acquisition cost to the new owner; or
> (iii) The fair market value of the asset on the date of acquisition.

In reviewing the Asset Purchase Agreement, the Allocation Agreement and other items in the record, the Board finds that:

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[7] Intermediary Post-Hearing Brief at p.13-14.

1. The sale was negotiated at arms length, with each side represented by counsel.
2. The values were supported by a detailed appraisal that was represented to be done in accordance with Medicare principles.
3. The buyers did not question the asset valuations until the Board hearing.
4. The Provider's financial statements used property values consistent with the appraisal.

The Board, therefore, finds no valid reason to revalue the assets as advocated by the Provider.

DECISION AND ORDER:

The Intermediary's adjustments disallowing the interest expense was proper and is affirmed.

BOARD MEMBERS PARTICIPATING:

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

FOR THE BOARD

DATE: December 2, 2004

Suzanne Cochran, Esquire
Chairman